

Search Tip:

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar or using the CTRL+F search function from your keyboard. It will then display a search box for you to type in the name of the drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

SISC - Book of Business Drug List
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
abacavir soln (ZIAGEN equiv)	-	G	ANTIVIRALS
abacavir tab (ZIAGEN equiv)	-	G	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	G	ANTIVIRALS
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	G	ANTIVIRALS
ABILIFY MYCITE PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ABILIFY MYCITE TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
abiraterone acetate tab 500mg (ZYTIGA equiv)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tabs/day)	LMSP-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABRILADA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ABRYSVO INJ	VAC	\$0	VACCINES
ABSORICA CAP	-	NC	DERMATOLOGICALS
ABSORICA LD CAP	-	NC	DERMATOLOGICALS
ABSTRAL SL TAB (QL= 120 tabs/30 days)	PA-QL	B	ANALGESICS - OPIOID
acamprosate calcium DR tab (CAMPRAL equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	G	ANTIDIABETICS
ACCRUFER CAP	-	NC	HEMATOPOIETIC AGENTS
ACCU-CHEK AVIVA PLUS METER	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
ACCU-CHEK GUIDE CARE METER	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE ME KIT	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
ACCU-CHEK GUIDE TEST STRIP	OTC-PA	NC	DIAGNOSTIC PRODUCTS
ACCU-CHEK NANO METER	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK SMARTVIEW TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
ACCU-CHEK TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
ACCURETIC TAB	-	B	ANTIHYPERTENSIVES
acebutolol cap (SECTRAL equiv)	-	G	BETA BLOCKERS
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC	ANALGESICS - OPIOID
acetaminophen/codeine soln	-	G	ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	G	ANALGESICS - OPIOID
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC	MIGRAINE PRODUCTS
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC	MIGRAINE PRODUCTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	G	DIURETICS
acetazolamide tab	-	G	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	G	OTIC AGENTS
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	G	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	G	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	G	COUGH/COLD/ALLERGY
ACIPHEX SPRINKLE CAP	-	NC	ULCER DRUGS
ACIPHEX SPRINKLE CAP 10MG, RABEPRAZOLE SPRINKLE CAP 10MG	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGIC

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
acitretin cap (SORIATANE equiv)	-	G	DERMATOLOGICALS
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA IV INJ	MSP-PA	B	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTHIB INJ, HIBERIX INJ	VAC	\$0	VACCINES
ACTICLATE TAB 75MG, 150MG	-	NC	TETRACYCLINES
ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B	ANTINEOPLASTICS
ACTIVE OB	-	NC	MULTIVITAMINS
ACTOPLUS MET TAB	-	NC	ANTIDIABETICS
ACUVAIL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
acyclovir cap (ZOVIRAX equiv)	-	G	ANTIVIRALS
acyclovir cream (ZOVIRAX equiv)	-	NC	DERMATOLOGICALS
acyclovir oint (ZOVIRAX OINT equiv)	-	G	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	G	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	G	ANTIVIRALS
ADACEL/BOOSTRIX INJ	VAC	\$0	TOXOIDS
ADAGEN INJ	MSP-PA	B	BIOLOGICALS MISC
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ PFS INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADAPALENE SOLN	-	NC	DERMATOLOGICALS
adapalene cream (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
ADAPALENE LOTION (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	G	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	NC	DERMATOLOGICALS
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC	DERMATOLOGICALS
ADASUVE INHALER	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ADAZIN CREAM	-	NC	DERMATOLOGICALS
ADBRY INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
ADCIRCA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ADDERALL XR CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ADDYI TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
adefovir dipivoxil tab (HEPSERA equiv)	-	G	ANTIVIRALS
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
ADLARITY PATCH	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ADLYXIN INJ	-	NC	ANTIDIABETICS
ADMELOG INJ, HUMALOG INJ	-	NC	ANTIDIABETICS
ADOXA CAP 150MG	-	NC	TETRACYCLINES
ADRENACLICK INJ, EPINEPHRINE INJ	-	NC	VASOPRESSORS
ADRENALIN NASAL SOLN	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ADVAIR DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ADZENYS ER SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ADZENYS XR TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
AEMCOLO TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
AEROCHAMBER	OTC	B	MEDICAL DEVICES AND SUPPLIES
AFINITOR DISPERZ TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFLURIA INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
AFSTYLA KIT	-	NC	HEMATOLOGICAL AGENTS - MISC.
AGAMREE SUSP	-	NC	CORTICOSTEROIDS
AGGRENOX CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	B	MIGRAINE PRODUCTS
AIRDUO POWDER INHALER W/SENSOR	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AIRDUO RESPICLICK	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AIRSUPRA INH	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	B	MIGRAINE PRODUCTS
AKEEGA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AKLIEF CREAM	-	NC	DERMATOLOGICALS
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	B	ANTIEMETICS
ALA-SCALP LOTION	-	NC	DERMATOLOGICALS
albuterol HFA inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL HFA INHALER	QL--	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL NEBULIZER SOLN	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL TAB ER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
alclometasone cream (ACLOVATE equiv)	-	G	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
alclometasone oint (ACLOVATE OINT equiv)	-	G	DERMATOLOGICALS
ALCOHOL SWABS	OTC	NC	MEDICAL DEVICES AND SUPPLIES
ALCORTIN A GEL (iodoquinol/hydrocortisone/aloe polysaccharide gel equiv)	-	NC	DERMATOLOGICALS
ALDURAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALECENSA CAP (QL= 8 caps/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alendronate sodium oral soln (FOSAMAX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
alendronate tab (FOSAMAX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALENDRONATE TAB 40MG	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALEVICYN SOLN DERMAL	-	NC	DERMATOLOGICALS
ALFERON-N INJ	LMSP	B	ANTINEOPLASTICS
alfuzosin SR tab (UROXATRAL equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	B	ANTI-INFECTIVE AGENTS - MISC.
aliskiren tab (TEKTURNA equiv)	-	G	ANTIHYPERTENSIVES
ALKINDI SPRINKLE CAP	-	NC	CORTICOSTEROIDS
ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Members age 9 or older require Prior Authorization)	PA-QL	B	CORTICOSTEROIDS
ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Members age 9 or older require Prior Authorization)	PA-QL	B	CORTICOSTEROIDS
allopurinol tab (ZYLOPRIM equiv)	-	G	GOUT AGENTS
ALLOPURINOL TAB	-	NC	GOUT AGENTS
ALLZITAL TAB	-	NC	ANALGESICS - NONNARCOTIC
almotriptan tab (AXERT equiv)	-	NC	MIGRAINE PRODUCTS
ALOCRILOPHTH SOLN	-	B	OPHTHALMIC AGENTS
ALOGLIPTIN TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN TAB, NESINA TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN-METFORMIN TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN-PIOGLITAZONE TAB	-	NC	ANTIDIABETICS
ALOMIDE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
ALOQUIN GEL	-	NC	DERMATOLOGICALS
ALORA PATCH	-	NC	ESTROGENS
alosetron tab (LOTRONEX equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPHTH SOLN 0.15%	-	NC	OPHTHALMIC AGENTS
ALPHANATE/HEMOPIL/KOATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ALPHANINE SD/MONONINE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
alprazolam ER tab (XANAX XR equiv)	-	G	ANTIANKXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	G	ANTIANKXIETY AGENTS
alprazolam tab (XANAX equiv)	-	G	ANTIANKXIETY AGENTS
ALREX OPHTH SUSP	-	B	OPHTHALMIC AGENTS
ALREX OPHTH SUSP 0.2%	-	B	OPHTHALMIC AGENTS
ALSUMA INJ, ZEMBRACE SYMTOUCH INJ	-	NC	MIGRAINE PRODUCTS
ALTABAX OINT	-	NC	DERMATOLOGICALS
ALTOPREV TAB	-	NC	ANTIHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ALTRENO LOTION	-	NC	DERMATOLOGICALS
ALUNBRIG PAK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALVAIZ TAB	-	NC	HEMATOPOIETIC AGENTS
ALVESCO INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
alvimopan cap (ENTEREG equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
ALZAIR NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
amantadine cap (SYMMETREL equiv)	-	G	ANTIPARKINSON AGENTS
amantadine syrup (SYMMETREL equiv)	-	G	ANTIPARKINSON AGENTS
amantadine tab	-	G	ANTIPARKINSON AGENTS
AMBIEN CR TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
AMCINONIDE CREAM 0.1%	-	NC	DERMATOLOGICALS
AMCINONIDE LOTION	-	NC	DERMATOLOGICALS
amcinonide oint 0.1% (AMCINONIDE OINT equiv)	-	NC	DERMATOLOGICALS
AMCINONIDE OINTMENT	-	NC	DERMATOLOGICALS
AMERGE TAB	-	NC	MIGRAINE PRODUCTS
amethyst tab (LYBREL equiv)	-	\$0	CONTRACEPTIVES
amiloride tab (MIDAMOR equiv)	-	G	DIURETICS
AMILORIDE/HCTZ TAB	-	G	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	G	DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	G	HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	G	HEMOSTATICS
amiodarone tab (CORDARONE equiv)	-	G	ANTIARRHYTHMICS
AMITIZA CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
amitriptyline tab (ELAVIL equiv)	-	G	ANTIDEPRESSANTS
AMJEVITA AUTO-INJECTOR (adalimumab-atto)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
AMJEVITA INJ (adalimumab-atto)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
amlodipine tab (NORVASC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
amlodipine/atorvastatin tab (CADUET equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
amlodipine/benazepril cap (LOTREL equiv)	-	G	ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR equiv)	-	NC	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	G	ANTIHYPERTENSIVES
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	NC	ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	EXC	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	EXC	DERMATOLOGICALS
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	G	DERMATOLOGICALS
amoxapine tab (AMOXAPINE equiv)	-	G	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	G	PENICILLINS
AMOXICILLIN CHEW TAB	-	G	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	G	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	G	PENICILLINS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
AMOXICILLIN/CLAVULANATE ER TAB	-	B	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	G	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	G	PENICILLINS
AMPHETAMINE ER SUSP, DYANAVEL XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine tab (EVEKEO equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 25mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 50mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ampicillin cap (AMPICILLIN equiv)	-	G	PENICILLINS
AMZEEQ FOAM	-	NC	DERMATOLOGICALS
anagrelide cap (AGRYLIN equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
ANALPRAM-E KIT	-	B	ANORECTAL AGENTS
ANALPRAM-HC CREAM	-	B	ANORECTAL AND RELATED PRODUCTS
ANAPROX TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ANASTIA LOTION	-	NC	DERMATOLOGICALS
anastrozole tab (ARIMIDEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	B	ANDROGENS-ANABOLIC
ANDROGEL 1% 25MG	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1% 50MG, TESTIM GEL 1%	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 1.25GM	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 2.5GM	-	NC	ANDROGENS-ANABOLIC
ANDROGEL PUMP 1%	-	NC	ANDROGENS-ANABOLIC
ANGELIQ TAB	-	NC	ESTROGENS
ANNOVERA RING	-	NC	CONTRACEPTIVES
ANORO ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ANTARA CAP, FENOFIBRATE MICRONIZED CAP	-	NC	ANTIHYPERLIPIDEMICS
ANTARA CAP, LOFIBRA CAP	-	NC	ANTIHYPERLIPIDEMICS
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC	OTIC AGENTS
ANTIVERT TAB, MECLIZINE TAB	-	NC	ANTIEMETICS
anusol-HC supp	-	NC	ANORECTAL AGENTS
ANZEMET TAB (QL= 9 tabs/fill)	QL	B	ANTIEMETICS
APADAZ TAB	-	NC	ANALGESICS - OPIOID
APAP/CODEINE SOLN	-	G	ANALGESICS - OPIOID
APEXICON E CREAM (PSORCON E equiv)	-	NC	DERMATOLOGICALS
APIDRA INJ	-	NC	ANTIDIABETICS
APIDRA SOLOSTAR INJ	-	NC	ANTIDIABETICS
APLENZIN TAB	-	NC	ANTIDEPRESSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
APOKYN INJ	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
apomorphine inj (APOKYN equiv)	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
APRACLONIDINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
apraclonidine ophth soln (IOPIDINE equiv)	-	G	OPHTHALMIC AGENTS
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	G	ANTIEMETICS
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	G	ANTIEMETICS
APRISO CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
APRIZIO PAK KIT	-	NC	DERMATOLOGICALS
APTENSIO XR CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
APTIOM TAB	-	NC	ANTICONVULSANTS
APTIVUS CAP	-	B	ANTIVIRALS
APTIVUS SOLN	-	B	ANTIVIRALS
ARAKODA TAB	-	NC	ANTIMALARIALS
ARALAST/PROLASTIN/ZEMAIRA INJ	MSP-PA	B	RESPIRATORY AGENTS - MISC.
ARANESP INJ	-	NC	HEMATOPOIETIC AGENTS
ARAZLO LOTION	-	NC	DERMATOLOGICALS
ARCALYST INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
AREXVY INJ	VAC	\$0	VACCINES
arformoterol tartrate neb soln (BROVANA equiv) (Step Therapy requires trial of PERFORMOMIST)	ST	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046)	LD-PA-QL	B	AMINOGLYCOSIDES
aripiprazole ODT (ABILIFY equiv)	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ARIXTRA INJ	-	NC	ANTICOAGULANTS
armodafanil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ARMONAIR DIGITAL INHALER 113MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMONAIR DIGITAL INHALER 232MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMONAIR DIGITAL INHALER 55MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMOUR THYROID TAB, NATURE THROID TAB	-	G	THYROID AGENTS
ARNUIITY ELLIPTA INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARTHROTEC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ARYMO ER TAB	-	NC	ANALGESICS - OPIOID
ARZERRA INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ASACOL HD TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
ASACOL HD TAB, MESALAMINE TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	\$0	CONTRACEPTIVES
ASMANEX HFA INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ASMANEX INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
aspirin chew tab 81mg (Covered for females up to 60 years of age)	OTC	\$0	ANALGESICS - NONNARCOTIC
ASPIRIN EC TAB 325MG	OTC	NC	ANALGESICS - NONNARCOTIC
aspirin ec tab 81mg (Covered for females up to 60 years of age)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 325mg	OTC	NC	ANALGESICS - NONNARCOTIC
aspirin/codeine tab	-	G	ANALGESICS - OPIOID
aspirin/dipyridamole cap (AGGRENOLX equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
ASPIRIN/OMEPRAZOLE ER TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
ASPRUZYO SPRINKLE GRANULES	-	NC	ANTIANGINAL AGENTS
ASTAGRAF XL CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ASTAMED MYO CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ASTEPRO NASAL SPRAY (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	B	NASAL AGENTS - SYSTEMIC AND TOPICAL
ATACAND TAB	-	NC	ANTIHYPERTENSIVES
atazanavir cap (REYATAZ equiv)	-	G	ANTIVIRALS
atenolol tab (TENORMIN equiv)	-	G	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	G	ANTIHYPERTENSIVES
atomoxetine cap (STRATTERA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ATORVALIQ SUSP (Members age 9 or older require Prior Authorization)	PA	B	ANTIHYPERLIPIDEMICS
atorvastatin tab (LIPITOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	G	ANTIMALARIALS
ATRALIN GEL	-	NC	DERMATOLOGICALS
ATRIPLA TAB	-	NC	ANTIVIRALS
ATRIX SYSTEM KIT	-	NC	DERMATOLOGICALS
atropine ophth oint	-	G	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	G	OPHTHALMIC AGENTS
ATROPINE SUL SOLN 1% OPHTH	-	G	OPHTHALMIC AGENTS
ATROPINE SULFATE OPHTH OINT	-	G	OPHTHALMIC AGENTS
ATROVENT HFA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AUBAGIO TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUGTYRO CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AURYXIA TAB (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B	GASTROINTESTINAL AGENTS - MISC.
AUSTEDO TAB (QL= 4 tabs/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO TITRATION PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB 6MG (QL= 3 tabs/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUVELITY TAB	-	NC	ANTIDEPRESSANTS
AUVI-Q INJ	-	NC	VASOPRESSORS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
AVAR AEROSOL FOAM	-	NC	DERMATOLOGICALS
AVAR GEL	-	NC	DERMATOLOGICALS
AVAR PAD	-	NC	DERMATOLOGICALS
AVAR-E LS CREAM 10-2%	-	NC	DERMATOLOGICALS
AVASTIN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AVONEX INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVSOLA INJ	MSP-PA	B	GASTROINTESTINAL AGENTS - MISC.
AXERT TAB	-	NC	MIGRAINE PRODUCTS
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
azacitidine inj (VIDAZA equiv)	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AZASITE SOLN	-	B	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	G	ASSORTED CLASSES
azathioprine tab 100mg (AZASAN equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
azathioprine tab 75mg (AZASAN equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
azelaic acid gel (FINACEA equiv)	-	G	DERMATOLOGICALS
azelastine nasal spray 0.1% (ASTELIN equiv)	-	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine nasal spray 0.15% (ASTEPRO equiv) (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	G	OPHTHALMIC AGENTS
azelastine/fluticasone nasal spray (DYMISTA equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
AZELEX CREAM	-	NC	DERMATOLOGICALS
AZENASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
AZESCHEW TAB	-	NC	MULTIVITAMINS
AZESCO TAB	-	NC	MULTIVITAMINS
azithromycin susp (ZITHROMAX equiv)	-	G	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	G	MACROLIDES
AZOPT OPHTH SUSP	-	B	OPHTHALMIC AGENTS
AZOR TAB	-	NC	ANTIHYPERTENSIVES
AZSTARYS CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
BACITRACIN OPHTH OINT	-	B	OPHTHALMIC AGENTS
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	G	OPHTHALMIC AGENTS
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	G	OPHTHALMIC AGENTS
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	G	OPHTHALMIC AGENTS
BACLOFEN CREAM COMPOUND KIT	-	B	DERMATOLOGICALS
BACLOFEN ORAL SOLN 10 MG/5ML (Prior Authorization Required for members age 9 and older)	PA	B	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN ORAL SOLN 5 MG/5ML (Prior Authorization Required for members age 9 and older)	PA	B	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN SUSP (Prior Authorization Required for members age 9 or older)	PA	B	MUSCULOSKELETAL THERAPY AGENTS
baclofen susp (BACLOFEN equiv) (Prior Authorization Required for members age 9 or older)	PA	G	MUSCULOSKELETAL THERAPY AGENTS
baclofen tab (BACLOFEN equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN TAB 5MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
BACTROBAN CREAM	-	NC	DERMATOLOGICALS
BACTROBAN NASAL OINT (QL= 10 tubes/fill)	QL	B	NASAL AGENTS - SYSTEMIC AND TOPICAL

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
BAFIERTAM CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BALCOLTRA TAB	-	NC	CONTRACEPTIVES
balsalazide cap (COLAZAL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BANZEL SUSP	PA	B	ANTICONSULTANTS
BANZEL TAB	-	NC	ANTICONSULTANTS
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	B	ANTIDIABETICS
BARACLUDE SOLN (Members age 9 or older require Prior Authorization)	PA	B	ANTIVIRALS
BASAGLAR INJ, LANTUS SOLOSTAR INJ, INSULIN GLARGINE SOLOSTAR I	-	NC	ANTIDIABETICS
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	B	FLUOROQUINOLONES
BCG INJ	VAC	EXC	VACCINES
B-D INSULIN SYRINGE	--OTC	G	MEDICAL DEVICES AND SUPPLIES
B-D PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
b-donna tab (DONNATAL equiv)	-	NC	ULCER DRUGS
BEBULIN/PROFILNINE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
BECONASE AQ NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
BELBUCA FILM	-	NC	ANALGESICS - OPIOID
BELLADONNA ALKALOID/OPIUM SUPP	-	B	ULCER DRUGS
BELSOMRA TAB	-	NC	HYPNOTICS
benazepril tab (LOTENSIN equiv)	-	G	ANTIHYPERTENSIVES
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	G	ANTIHYPERTENSIVES
bendamustine hcl for iv soln (TREANDA equiv)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BENEFIX INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
BENEFIX/RIXUBIS INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
BENICAR HCT TAB	-	NC	ANTIHYPERTENSIVES
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	LMSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
BENLYSTA INJ (QL= 4 inj/28 day)	LMSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
BENTIVITE TAB	-	NC	HEMATOPOIETIC AGENTS
BENZAC WASH	-	NC	DERMATOLOGICALS
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	B	ANTHELMINTICS
benzonatate cap (TESSALON equiv)	-	G	COUGH/COLD/ALLERGY
benzonatate cap 150mg (ZONATUSS equiv)	-	NC	COUGH/COLD/ALLERGY
BENZOYL PEROXIDE CREAM	OTC	NC	DERMATOLOGICALS
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC	DERMATOLOGICALS
benzoyl peroxide/hydrocortisone lotion (VANOXIDE-HC equiv)	-	NC	DERMATOLOGICALS
benzphetamine tab	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
benztropine tab	-	G	ANTIPARKINSON AGENTS
bepotastine ophth soln (BEPREVE equiv)	-	NC	OPHTHALMIC AGENTS
BERINERT INJ (Only available through Accredo 800-803-2523)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
BESER KIT 0.05%	-	NC	DERMATOLOGICALS
BESIVANCE OPHTH SUSP	-	NC	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
BESREMI INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
betaine powder for oral solution (CYSTADANE equiv) (Only available through Walgreens 888-347-3416)	LD	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	G	DERMATOLOGICALS
BETAMETHASONE AUGMENTED GEL	-	B	DERMATOLOGICALS
betamethasone augmented gel	-	G	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	G	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	G	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	G	DERMATOLOGICALS
betamethasone dipropionate lotion	-	G	DERMATOLOGICALS
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	G	DERMATOLOGICALS
betamethasone valerate cream	-	G	DERMATOLOGICALS
betamethasone valerate foam (LUXIQ equiv)	-	NC	DERMATOLOGICALS
betamethasone valerate lotion	-	G	DERMATOLOGICALS
betamethasone valerate oint	-	G	DERMATOLOGICALS
BETASERON INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BETAXOLOL OPTH SOLN	-	G	OPHTHALMIC AGENTS
betaxolol ophth soln (BETOPTIC-S equiv)	-	G	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	G	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	G	URINARY ANTISPASMODICS
BETIMOL OPTH SOLN	-	B	OPHTHALMIC AGENTS
BETOPTIC-S OPTH SOLN	-	B	OPHTHALMIC AGENTS
BEVESPI AEROSPHERE INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BEXAGLIFLOZN TAB	-	NC	ANTIDIABETICS
bexarotene cap (TARGRETIN equiv)	LMSP-PA-SF	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bexarotene gel (TARGRETIN equiv)	LMSP-PA	G	DERMATOLOGICALS
BEXSERO INJ	VAC	\$0	VACCINES
BEYFORTUS INJ	VAC	\$0	PASSIVE IMMUNIZING AND TREATMENT AGENTS
BIAFINE EMULSION	-	NC	DERMATOLOGICALS
bicalutamide tab (CASODEX equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIDIL TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
BIFERARX TAB	-	NC	HEMATOPOIETIC AGENTS
BIJUVA CAP	-	NC	ESTROGENS
BIKTARVY TAB	-	B	ANTIVIRALS
BILTRICIDE TAB	-	B	ANTHELMINTICS
bimatoprost ophth soln	-	EXC	DERMATOLOGICALS
bimatoprost ophth soln	-	NC	OPHTHALMIC AGENTS
BIMZELX INJ	-	NC	DERMATOLOGICALS
BINOSTO TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
bismuth/metro/tetra cap (PYLERA equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
bisoprolol tab (ZEBETA equiv)	-	G	BETA BLOCKERS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	G	ANTIHYPERTENSIVES
BLEPHAMIDE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
BLEPHAMIDE S.O.P. OPHTH OINT	-	B	OPHTHALMIC AGENTS
BORTEZOMIB INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bortezomib inj (VELCADE equiv)	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
BOSULIF CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOSULIF TAB	MSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOTOX INJ	MSP-PA	B	NEUROMUSCULAR AGENTS
BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BREO ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREO ELLIPTA INHALER 50-25 MCG/ACT	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREXAFEMME TAB	-	NC	ANTIFUNGALS
BREZTRI AEROSPHERE INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BRILINTA TAB	-	B	HEMATOLOGICAL AGENTS - MISC.
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	G	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2%	-	G	OPHTHALMIC AGENTS
brimonidine tartrate gel (MIRVASO equiv)	-	EXC	DERMATOLOGICALS
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	G	OPHTHALMIC AGENTS
brimonidine/timolol ophth soln (COMBIGAN OPHTH SOLN equiv)	-	G	OPHTHALMIC AGENTS
brinzolamide ophth susp (AZOPT equiv)	-	G	OPHTHALMIC AGENTS
BRISDELLE CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BRIVIACT INJ 50MG/5ML	-	NC	ANTICONVULSANTS
BRIVIACT SOLN 10MG/ML	-	NC	ANTICONVULSANTS
BRIVIACT TAB	-	NC	ANTICONVULSANTS
BRIXADI SOLN 128MG/0.36ML (Only available through Walgreens 888-347-3416)	LD	B	ANALGESICS - OPIOID
BRIXADI SOLN 16MG/0.32ML (Only available through Walgreens 888-347-3416)	LD	B	ANALGESICS - OPIOID
BRIXADI SOLN 24MG/0.48ML (Only available through Walgreens 888-347-3416)	LD	B	ANALGESICS - OPIOID
BRIXADI SOLN 32MG/0.64ML (Only available through Walgreens 888-347-3416)	LD	B	ANALGESICS - OPIOID
BRIXADI SOLN 64MG/0.18ML (Only available through Walgreens 888-347-3416)	LD	B	ANALGESICS - OPIOID
BRIXADI SOLN 8MG/0.16ML (Only available through Walgreens 888-347-3416)	LD	B	ANALGESICS - OPIOID
BRIXADI SOLN 96MG/0.27ML (Only available through Walgreens 888-347-3416)	LD	B	ANALGESICS - OPIOID
bromfenac ophth soln (BROMDAY equiv)	-	G	OPHTHALMIC AGENTS
bromfenac sodium ophth soln 0.07% (PROLENSA equiv)	-	NC	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
bromfenac sodium ophth soln 0.075% (BROMSITE equiv)	-	NC	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	G	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	G	ANTIPARKINSON AGENTS
BROMSITE DROP 0.075%	-	NC	OPHTHALMIC AGENTS
BRONCHITOL CAP	-	NC	RESPIRATORY AGENTS - MISC.
BRUKINSA CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRYHALI LOTION	-	NC	DERMATOLOGICALS
B-SERENE PAD	-	NC	HEMATOPOIETIC AGENTS
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	G	CORTICOSTEROIDS
budesonide inh susp (PULMICORT equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide nasal spray (RHINOCORT AQUA equiv)	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
budesonide rectal foam (UCERIS RECTAL FOAM equiv)	-	B	ANORECTAL AND RELATED PRODUCTS
budesonide SR cap (ENTOCORT EC equiv)	-	G	CORTICOSTEROIDS
budesonide/formoterol inhaler (SYMBICORT equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
bumetanide tab (BUMEX equiv)	-	G	DIURETICS
BUNAVAIL FILM	-	NC	ANALGESICS - OPIOID
bupap tab	-	NC	ANALGESICS - NONNARCOTIC
buprenorphine hcl buccal film (BELBUCA equiv)	-	NC	ANALGESICS - OPIOID
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days)	QL	G	ANALGESICS - OPIOID
buprenorphine SL tab (SUBUTEX equiv)	-	G	ANALGESICS - OPIOID
buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv)	-	G	ANALGESICS - OPIOID
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	G	ANALGESICS - OPIOID
bupropion ER tab (WELLBUTRIN equiv)	-	G	ANTIDEPRESSANTS
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	G	ANTIDEPRESSANTS
bupropion XL tab (WELLBUTRIN XL equiv)	-	G	ANTIDEPRESSANTS
bupirone tab (BUSPAR equiv)	-	G	ANTIAXIETY AGENTS
bupirone tab 30mg (BUSPAR equiv)	-	NC	ANTIAXIETY AGENTS
butalbital/acetaminophen cap	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen tab 50-325mg (PHRENILIN equiv) (QL= 60 tabs/30 days)	PA-QL	G	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine cap (FIORICET equiv)	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine soln	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine tab (FIORICET equiv) (QL= 60 tabs/30 days)	PA-QL	G	ANALGESICS - NONNARCOTIC
butalbital/aspirin/caffeine cap (FIORINAL equiv) (QL= 60 tabs/30 days)	PA-QL	G	ANALGESICS - NONNARCOTIC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC	ANALGESICS - NONNARCOTIC
BUTISOL TAB	-	B	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	G	ANALGESICS - OPIOID
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
BYDUREON INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
BYETTA INJ (Step Therapy requires trial of VICTOZA or BYDUREON; Diagnosis Restricted – Type 2 Diabetes (E11))	RDX-ST	B	ANTIDIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYNFEZIA PEN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BYVALSON TAB	-	NC	ANTIHYPERTENSIVES
CABENUVA IM SUSP	-	NC	ANTIVIRALS
cabergoline tab (DOSTINEX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
CABLIVI INJ KIT (QL= 1 vial/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAFCIT INJ	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
calcipotriene cream (DOVONEX CREAM equiv)	-	G	DERMATOLOGICALS
calcipotriene cream (TRIONEX equiv)	-	NC	DERMATOLOGICALS
CALCIPOTRIENE FOAM	-	NC	DERMATOLOGICALS
CALCIPOTRIENE FOAM, SORILUX FOAM	-	NC	DERMATOLOGICALS
calcipotriene oint	-	G	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	G	DERMATOLOGICALS
calcipotriene/betamethasone dipropionate susp (TACLONEX equiv)	-	NC	DERMATOLOGICALS
calcipotriene/betamethasone oint (TACLONEX equiv)	-	NC	DERMATOLOGICALS
calcitonin inj (MIACALCIN equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitonin nasal spray (MIACALCIN equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL INJ	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL OINT	-	NC	DERMATOLOGICALS
calcitriol soln (ROCALTROL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
CALIBRATION LIQUID	OTC	G	MEDICAL DEVICES AND SUPPLIES
CALQUENCE CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CALSODORE PAK	-	NC	DERMATOLOGICALS
CAMBIA POWDER	-	NC	MIGRAINE PRODUCTS
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
candesartan tab (ATACAND equiv)	-	NC	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	NC	ANTIHYPERTENSIVES
capecitabine tab (XELODA equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPEX SHAMPOO	-	NC	DERMATOLOGICALS
CAPLYTA CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
capsaicin/menthol topical patch (SINELEE equiv)	-	NC	DERMATOLOGICALS
captopril tab (CAPOTEN equiv)	-	G	ANTIHYPERTENSIVES
CARAC CREAM	-	NC	DERMATOLOGICALS
CARBAGLU TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
carbamazepine chew tab (TEGRETOL equiv)	-	G	ANTICONVULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	G	ANTICONVULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	G	ANTICONVULSANTS
carbamazepine susp (TEGRETOL equiv)	-	G	ANTICONVULSANTS
carbamazepine tab (TEGRETOL equiv)	-	G	ANTICONVULSANTS
carbidopa tab (LODOSYN equiv)	-	G	ANTIPARKINSON AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	G	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA ODT	-	G	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	G	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	G	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	B	ANTIPARKINSON AGENTS
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	G	ANTIPARKINSON AND RELATED THERAPY AGENTS
CARBINOXAMINE SOLN	-	G	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	G	ANTIHISTAMINES
CARDURA XL TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
CARETOUCH MIS	OTC	G	MEDICAL DEVICES AND SUPPLIES
carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007)	LD-PA	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
CARIMUNE INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
carisoprodol tab (SOMA equiv) (QL= 90 tabs/90 days)	QL	G	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol tab 250mg (SOMA equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARISOPRODOL/ASPIRIN TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARMOL LOTION	-	NC	DERMATOLOGICALS
CAROSPIR SUSP (Prior Authorization required for members age 9 or older)	PA	B	DIURETICS
CARTEOLOL OPHTH SOLN	-	G	OPHTHALMIC AGENTS
carteolol ophth soln (OCUPRESS equiv)	-	G	OPHTHALMIC AGENTS
carvedilol phosphate ER cap (COREG CR equiv)	-	NC	BETA BLOCKERS
carvedilol tab (COREG equiv)	-	G	BETA BLOCKERS
CATAPRES-TTS PATCH	-	B	ANTIHYPERTENSIVES
CAVERJECT INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B	CARDIOVASCULAR AGENTS - MISC.
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	B	ANTI-INFECTIVE AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
CEFACTOR CAP	-	G	CEPHALOSPORINS
cefactor cap (CECLOR equiv)	-	G	CEPHALOSPORINS
CEFACTOR ER TAB	-	B	CEPHALOSPORINS
CEFACTOR SUSP	-	B	CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	G	CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	G	CEPHALOSPORINS
CEFADROXIL TAB	-	G	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	G	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	G	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	G	CEPHALOSPORINS
CEFDITOREN TAB	-	B	CEPHALOSPORINS
cefixime cap (SUPRAX equiv)	-	G	CEPHALOSPORINS
cefixime susp (SUPRAX equiv)	-	G	CEPHALOSPORINS
cefpodoxime proxetil susp (VANTIN equiv)	-	G	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	G	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	G	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	G	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	G	CEPHALOSPORINS
CELEBREX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
celecoxib cap (CELEBREX equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
CENTANY OINT	-	NC	DERMATOLOGICALS
cephalexin cap (KEFLEX equiv)	-	G	CEPHALOSPORINS
cephalexin cap 750mg (KEFLEX equiv)	-	NC	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	G	CEPHALOSPORINS
CEPHALEXIN TAB	-	NC	CEPHALOSPORINS
CEQUA (PF) OPHTH SOLN, VEVYE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
CEQR SIMPLICITY	-	NC	MEDICAL DEVICES AND SUPPLIES
CERDELGA CAP	-	NC	HEMATOPOIETIC AGENTS
CEREZYME INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
CERVICAL CAP	-	\$0	MEDICAL DEVICES AND SUPPLIES
CESAMET CAP	-	B	ANTIEMETICS
cetrotexil acetate for inj kit (CETROTIDE equiv)	INF-MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETROTIDE KIT	INF-MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETYLEV TAB	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
cevimeline cap (EVOXAC equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
CHEMET CAP	-	B	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	G	ANTIANSXIETY AGENTS
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	G	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
chloroquine tab (ARALEN equiv)	-	G	ANTIMALARIALS
CHLOROTHIAZIDE TAB	-	G	DIURETICS
chlorothiazide tab (DIURIL equiv)	-	G	DIURETICS
CHLORPROMAZINE CONC	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
chlorpromazine tab (THORAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
chlorthalidone tab	-	G	DIURETICS
chlorzoxazone tab	-	NC	MUSCULOSKELETAL THERAPY AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
chlorzoxazone tab 500mg	-	G	MUSCULOSKELETAL THERAPY AGENTS
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	B	GASTROINTESTINAL AGENTS - MISC.
cholestyramine lite powder (QUESTRAN LITE equiv)	-	G	ANTIHYPERLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	G	ANTIHYPERLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	G	ANTIHYPERLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	G	ANTIHYPERLIPIDEMICS
CIBINQO TAB (QL= 1 tab/day)	LMSP-PA-QL	B	DERMATOLOGICALS
cicatrace kit (REXASIL equiv)	-	NC	DERMATOLOGICALS
CICLODAN KIT	-	NC	DERMATOLOGICALS
ciclopirox cream (LOPROX CREAM equiv)	-	G	DERMATOLOGICALS
ciclopirox gel (LOPROX equiv)	-	NC	DERMATOLOGICALS
ciclopirox nail soln (PENLAC equiv)	-	G	DERMATOLOGICALS
ciclopirox shampoo (LOPROX equiv) (Step Therapy requires trial of ketoconazole shampoo)	ST	G	DERMATOLOGICALS
ciclopirox topical susp (LOPROX equiv)	-	NC	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
CILOXAN OPHTH OINT	-	B	OPHTHALMIC AGENTS
CIMDUO TAB	-	B	ANTIVIRALS
CIMETIDINE SOLN	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
cimetidine soln (CIMETIDINE equiv)	-	G	ULCER DRUGS
cimetidine tab (TAGAMET equiv) (Rx Only)	-	G	ULCER DRUGS
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
CIMZIA INJ	LMSP-PA-QL	NC	GASTROINTESTINAL AGENTS - MISC.
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
cinacalcet tab (SENSIPAR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
CIPRO HC OTIC SUSP (Step Therapy requires trial of CIPRODEX)	ST	B	OTIC AGENTS
CIPRO SUSP	-	B	FLUOROQUINOLONES
CIPROFLOXACIN 100MG TAB	-	B	FLUOROQUINOLONES
ciprofloxacin ophth soln (CILOXAN equiv)	-	G	OPHTHALMIC AGENTS
CIPROFLOXACIN OTIC SOLN	-	B	OTIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	G	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	G	FLUOROQUINOLONES
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	G	OTIC AGENTS
CITALOPRAM CAP	-	NC	ANTIDEPRESSANTS
citalopram soln (CELEXA equiv)	-	G	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	G	ANTIDEPRESSANTS
CITRANATAL 90 DHA, CITRANATAL ASSURE	-	NC	MULTIVITAMINS
CITRANATAL B CALM	-	NC	MULTIVITAMINS
CITRANATAL BLOOM	-	NC	MULTIVITAMINS
CITRANATAL CAP MEDLEY	-	NC	MULTIVITAMINS
CITRANATAL HARMONY	-	NC	MULTIVITAMINS
CITRANATAL RX	-	NC	MULTIVITAMINS
CITRULLINE EASY TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
CLARINEX SYRUP	-	EXC	ANTIHISTAMINES
CLARINEX TAB	-	EXC	ANTIHISTAMINES
CLARINEX-D TAB	-	EXC	COUGH/COLD/ALLERGY
CLARITHROMYC SUSP	-	B	MACROLIDES
clarithromycin ER tab (BIAXIN XL equiv)	-	NC	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	G	MACROLIDES
CLARITIN CAP	OTC	EXC	ANTIHISTAMINES
CLARITIN CHEW TAB	OTC	EXC	ANTIHISTAMINES
CLENIA PLUS SUSP	-	NC	DERMATOLOGICALS
CLENPIQ SOLN	-	NC	LAXATIVES
CLEOCIN VAGINAL SUPP	-	NC	VAGINAL PRODUCTS
CLIMARA PATCH	-	NC	ESTROGENS
CLIMARA PRO PATCH	-	NC	ESTROGENS
CLINDACIN KIT	-	NC	DERMATOLOGICALS
clindamycin cap (CLEOCIN equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
clindamycin cap 300mg (CLEOCIN equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
clindamycin foam (EVOCLIN equiv)	-	NC	DERMATOLOGICALS
clindamycin gel (CLEOCIN GEL equiv)	-	G	DERMATOLOGICALS
clindamycin gel 1% (CLEOCIN GEL equiv)	-	NC	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	G	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	G	DERMATOLOGICALS
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv)	-	NC	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	G	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	G	VAGINAL PRODUCTS
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	G	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	NC	DERMATOLOGICALS
clindamycin/tretinoin gel (ZIANA equiv)	-	NC	DERMATOLOGICALS
CLINDAVIX KIT	-	NC	DERMATOLOGICALS
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	B	VAGINAL AND RELATED PRODUCTS
CLINISTIX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
clobazam susp (ONFI equiv) (Members age 9 or older require Prior Authorization)	PA	G	ANTICONVULSANTS
clobazam tab (ONFI equiv)	PA	G	ANTICONVULSANTS
clobetasol E foam (OLUX E equiv)	-	NC	DERMATOLOGICALS
clobetasol foam (OLUX equiv)	PA	G	DERMATOLOGICALS
clobetasol lotion (CLOBEX equiv)	PA	G	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	-	G	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	G	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	G	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	G	DERMATOLOGICALS
clobetasol propionate soln (TEMOVATE equiv)	-	G	DERMATOLOGICALS
clobetasol shampoo (CLOBEX equiv)	-	G	DERMATOLOGICALS
clobetasol spray (CLOBEX equiv)	-	G	DERMATOLOGICALS
CLOBETAVIX KIT	-	NC	DERMATOLOGICALS
CLOBEX LOTION	-	NC	DERMATOLOGICALS
CLOBEX SHAMPOO	-	NC	DERMATOLOGICALS
CLOCORTOLONE CREAM	-	NC	DERMATOLOGICALS
clocortolone pivalate cream	-	NC	DERMATOLOGICALS
CLODERM CREAM	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	Plan Exclusion	INF Infertility	LD Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
RS	Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
ST	Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
	Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
CLOMID TAB	INF	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CLOMIPHENE TAB	INF	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
clomipramine cap (ANAFRANIL equiv)	-	G	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	G	ANTICONVULSANTS
clonazepam tab (KLONOPIN equiv)	-	G	ANTICONVULSANTS
clonidine ER tab (KAPVAY equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
clonidine patch (CATAPRES-TTS equiv)	-	G	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	G	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
CLOPIDOGREL THERAPY PACK	-	NC	HEMATOLOGICAL AGENTS - MISC.
clorazepate tab (TRANXENE-T equiv)	-	G	ANTIANKXIETY AGENTS
clotrimazole cream (LOTRIMIN AF equiv) (Rx Only)	OTC	EXC	DERMATOLOGICALS
clotrimazole troches (MYCELEX TROCHES equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
clotrimazole/betamethasone cream (LOTRISONE equiv)	-	NC	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LOTRISONE equiv)	-	NC	DERMATOLOGICALS
CLOZAPINE ODT	-	NC	ANTI PSYCHOTICS/ANTIMANIC AGENTS
clozapine odt tab (CLOZAPINE, FAZACLO equiv)	-	NC	ANTI PSYCHOTICS/ANTIMANIC AGENTS
CLOZAPINE ODT, FAZACLO ODT	-	NC	ANTI PSYCHOTICS/ANTIMANIC AGENTS
clozapine tab (CLOZARIL equiv)	-	G	ANTI PSYCHOTICS/ANTIMANIC AGENTS
COCAINE HCL SOLN	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
CODEINE SULFATE SOLN	-	B	ANALGESICS - OPIOID
codeine sulfate tab	-	G	ANALGESICS - OPIOID
colchicine cap (MITIGARE equiv)	-	NC	GOUT AGENTS
colchicine tab (COLCRYS equiv)	-	G	GOUT AGENTS
colchicine/probenecid tab (COL-BENEMID equiv)	-	G	GOUT AGENTS
COLCRYS TAB	-	NC	GOUT AGENTS
colesevelam pack (WELCHOL equiv)	-	G	ANTIHYPERLIPIDEMICS
colesevelam tab (WELCHOL equiv)	-	G	ANTIHYPERLIPIDEMICS
colestipol granule (COLESTID equiv)	-	G	ANTIHYPERLIPIDEMICS
colestipol powder packet (COLESTID equiv)	-	G	ANTIHYPERLIPIDEMICS
colestipol tab (COLESTID equiv)	-	G	ANTIHYPERLIPIDEMICS
colistimethate inj (COLY-MYCIN M equiv)	LMSP	B	ANTI-INFECTIVE AGENTS - MISC.
COLLANEX EXTERNAL POWDER	-	NC	DERMATOLOGICALS
COLY-MYCIN S OTIC SUSP	-	B	OTIC AGENTS
COMBIGAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
COMBIPATCH	-	NC	ESTROGENS
COMBIVENT RESPIMAT INHALER	-	B	ANTI ASTHMATIC AND BRONCHODILATOR AGENTS
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	\$0	VACCINES
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	\$0	VACCINES
COMPLERA TAB	-	B	ANTIVIRALS
COMPLETE NATAL DHA	-	G	MULTIVITAMINS
CONCEPT DHA CAP	-	G	MULTIVITAMINS
CONDYLOX GEL	-	B	DERMATOLOGICALS
CONJUPRI TAB, LEVAMLODIPINE TAB	-	NC	CALCIUM CHANNEL BLOCKERS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumericera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
CONSENSI TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CONTRACEPTIVE FOAM	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE GEL	OTC	\$0	VAGINAL PRODUCTS
CONTRACEPTIVE SUPP	OTC	\$0	VAGINAL PRODUCTS
COPIKTRA CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CORDRAN CREAM 0.025%	-	NC	DERMATOLOGICALS
CORDRAN OINTMENT	-	NC	DERMATOLOGICALS
CORDRAN TAPE	-	NC	DERMATOLOGICALS
CORLANOR SOLN	PA	B	CARDIOVASCULAR AGENTS - MISC.
CORLANOR TAB	PA	B	CARDIOVASCULAR AGENTS - MISC.
CORTANE-B OTIC SOLN	-	NC	OTIC AGENTS
CORTEF TAB	-	NC	CORTICOSTEROIDS
CORTIC-ND DROPS	-	NC	OTIC AGENTS
CORTIFOAM	-	B	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	B	CORTICOSTEROIDS
CORTISPORIN CREAM	-	B	DERMATOLOGICALS
CORTISPORIN OINT	-	B	DERMATOLOGICALS
CORTROPHIN INJ GEL	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
COSENTYX INJ (1-PACK)	-	NC	DERMATOLOGICALS
COSENTYX INJ (2-PACK)	-	NC	DERMATOLOGICALS
COSENTYX INJ 300MG/2ML	-	NC	DERMATOLOGICALS
COTELLIC TAB (QL= 3 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COTEMPLA XR ODT	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
COVID-19 TEST	OTC	EXC	DIAGNOSTIC PRODUCTS
COVID-19 VACCINE BIVALENT BOOSTER INJ (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ 5-11Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-4Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-5Y (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE INJ (JANSSEN) (QL= 1 dose/45 days)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE INJ (NOVAVAX) (QL= 1 dose/17 days)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	\$0	VACCINES
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0	VACCINES
COXANTO CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
CREON CAP	-	B	DIGESTIVE AIDS
CRESEMBA CAP	-	NC	ANTIFUNGALS
CRESTOR TAB	-	NC	ANTHYPERLIPIDEMICS
CRINONE GEL	PA	B	VAGINAL PRODUCTS
CRIXIVAN CAP	-	B	ANTIVIRALS
cromolyn conc (GASTROCROM equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
cromolyn neb soln (INTAL equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
cromolyn ophth soln (CROLOM equiv)	-	G	OPHTHALMIC AGENTS
CROMOLYN SODIUM OPHTH SOLN	-	G	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
CROTAN LOTION	-	NC	DERMATOLOGICALS
cryselle tab	-	\$0	CONTRACEPTIVES
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EXC	DIAGNOSTIC PRODUCTS
CUE HEALTH MONITOR	OTC	EXC	DIAGNOSTIC PRODUCTS
CUTAQUIG INJ	-	NC	PASSIVE IMMUNIZING AND TREATMENT AGENTS
CUTIVATE LOTION	-	NC	DERMATOLOGICALS
CUVITRU INJ	-	NC	PASSIVE IMMUNIZING AGENTS
CUVRIOR TAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
cyanocobalamin inj	-	G	HEMATOPOIETIC AGENTS
cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv)	-	NC	HEMATOPOIETIC AGENTS
CYCLOBENZAPRINE COMPOUND KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine ER cap (AMRIX equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab (FLEXERIL equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CYCLOGYL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
CYCLOMYDRIL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	G	OPHTHALMIC AGENTS
cyclophosphamide cap	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOPHOSPHAMIDE TAB	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cycloserine cap (CYCLOSERINE CAP equiv)	-	NC	ANTIMYCOBACTERIAL AGENTS
CYCLOSET TAB	-	B	ANTIDIABETICS
cyclosporine cap (SANDIMMUNE equiv)	-	G	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	G	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	G	ASSORTED CLASSES
cyclosporine ophth emulsion (RESTASIS equiv)	PA	G	OPHTHALMIC AGENTS
CYCLOSPORINE OPHTH EMULSION 0.1%	-	NC	OPHTHALMIC AGENTS
CYFOLEX CAP	-	NC	HEMATOPOIETIC AGENTS
CYLTEZO AUTO-INJECTOR (adalimumab-adbm)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
CYLTEZO INJ (adalimumab-adbm)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
cyproheptadine syrup	-	G	ANTIHISTAMINES
cyproheptadine tab	-	G	ANTIHISTAMINES
CYSTADANE POWDER	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CYSTADANE POWDER	MSP-PA	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CYSTADROPS SOLN (QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	B	OPHTHALMIC AGENTS
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	B	GENITOURINARY AGENTS - MISCELLANEOUS
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B	OPHTHALMIC AGENTS
CYTRA K CRYSTALS	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
CYTRA-3 SYRUP	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	G	ANTICOAGULANTS
DAKLINZA TAB	-	NC	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist)	LMSP-QL-RS	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DALIRESP TAB	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
danazol cap (DANOCRINE equiv)	-	G	ANDROGENS-ANABOLIC
dantrolene cap (DANTRIUM equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
DAPAGLIFLOZIN PROP-METFORMIN HCL 10-1000MG	-	NC	ANTIDIABETICS
DAPAGLIFLOZIN PROP-METFORMIN HCL 5-1000MG	-	NC	ANTIDIABETICS
DAPAGLIFLOZIN PROPRANEDIOL TAB 10MG	-	NC	ANTIDIABETICS
DAPAGLIFLOZIN PROPRANEDIOL TAB 5MG	-	NC	ANTIDIABETICS
dapsone gel (ACZONE equiv)	-	NC	DERMATOLOGICALS
dapsone gel 5% (ACZONE equiv)	-	B	DERMATOLOGICALS
DAPSONE GEL 7.5%	-	NC	DERMATOLOGICALS
dapsone tab	-	G	ANTI-INFECTIVE AGENTS - MISC.
DAPTACEL INJ, INFANRIX INJ	VAC	\$0	TOXOIDS
darifenacin SR tab (ENABLEX equiv)	-	NC	URINARY ANTISPASMODICS
DARTISLA ODT TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
darunavir tab (PREZISTA equiv)	-	G	ANTIVIRALS
DAURISMO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
DAYVIGO TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
DAZOMON GEL	-	NC	DERMATOLOGICALS
DDAVP INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP NASAL SOLN	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
deferasirox granules packet (JADENU equiv)	LMSP	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (JADENU equiv)	LMSP	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab for oral susp (EXJADE equiv)	LMSP	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deflazacort tab (EMFLAZA equiv)	-	NC	CORTICOSTEROIDS
DEGLUDEC FLEXTOUCH INJ	-	NC	ANTIDIABETICS
DEGLUDEC INJ	-	NC	ANTIDIABETICS
DELESTROGEN INJ	-	NC	ESTROGENS
DELSTRIGO TAB	-	B	ANTIVIRALS
DELZICOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
demeclocycline tab (DECLOMYCIN equiv)	-	NC	TETRACYCLINES
DEMSEER CAP	-	NC	ANTIHYPERTENSIVES
DENAVIR CREAM	-	NC	DERMATOLOGICALS
DENGVAXIA SUSP	VAC	\$0	VACCINES
DEPACON INJ	-	NC	ANTICONVULSANTS
DEPLIN CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
DEPO-ESTRADIOL INJ	-	G	ESTROGENS
DEPO-MEDROL INJ	-	NC	CORTICOSTEROIDS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	NC	CORTICOSTEROIDS
DEPO-PROVERA INJ	-	NC	CONTRACEPTIVES
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
DERMACINRX CREAM	-	NC	DERMATOLOGICALS
DERMACINRX KIT	-	NC	DERMATOLOGICALS
DERMALID PAK	-	NC	DERMATOLOGICALS
DERMASORB XM KIT	-	B	DERMATOLOGICALS
DESCOVY TAB	PA	\$0	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	G	ANTIDEPRESSANTS
DESLORATADINE ODT	-	EXC	ANTIHISTAMINES
desloratadine tab (CLARINEX equiv)	-	EXC	ANTIHISTAMINES
desmopressin acetate nasal spray (DDAVP equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESONATE GEL	-	NC	DERMATOLOGICALS
desonide cream (DESOWEN equiv)	-	G	DERMATOLOGICALS
desonide gel	-	NC	DERMATOLOGICALS
desonide lotion (DESOWEN equiv)	-	NC	DERMATOLOGICALS
desonide oint (DESOWEN equiv)	-	G	DERMATOLOGICALS
DESOWEN CREAM	-	NC	DERMATOLOGICALS
DESOWEN CREAM KIT	-	NC	DERMATOLOGICALS
DESOWEN LOTION	-	NC	DERMATOLOGICALS
DESOWEN LOTION KIT	-	NC	DERMATOLOGICALS
DESOWEN OINT	-	NC	DERMATOLOGICALS
DESOWEN OINT KIT	-	NC	DERMATOLOGICALS
desoximetasone cream (TOPICORT CREAM equiv)	-	NC	DERMATOLOGICALS
desoximetasone cream 0.05% (TOPICORT equiv)	-	NC	DERMATOLOGICALS
desoximetasone gel (TOPICORT equiv)	-	NC	DERMATOLOGICALS
desoximetasone oint 0.05% (TOPICORT equiv)	-	NC	DERMATOLOGICALS
desoximetasone oint 0.25% (TOPICORT equiv)	-	G	DERMATOLOGICALS
desvenlafaxine ER tab (PRISTIQ equiv)	-	G	ANTIDEPRESSANTS
DESVENLAFAXINE ER TAB	-	NC	ANTIDEPRESSANTS
DETROL LA CAP	-	NC	URINARY ANTISPASMODICS
DEXAMETHASONE CONC	-	G	CORTICOSTEROIDS
dexamethasone elixir	-	G	CORTICOSTEROIDS
dexamethasone pak (DEXPAK equiv)	-	NC	CORTICOSTEROIDS
dexamethasone sodium phosphate inj	-	G	CORTICOSTEROIDS
DEXAMETHASONE SOLN	-	G	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	G	CORTICOSTEROIDS
DEXAMETHASONE TAB	-	NC	CORTICOSTEROIDS
DEXATRAN CAP	-	NC	MULTIVITAMINS
DEXCHLORPHENIRAMINE SYRUP	-	NC	ANTIHISTAMINES
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 SENSOR (QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXILANT DR CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
dexlansoprazole DR cap (DEXILANT equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dexmethylphenidate tab (FOCALIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DEXPAK TAB	-	NC	CORTICOSTEROIDS
DEXTENZA OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine soln (PROCENTRA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine sulfate tab 15mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine sulfate tab 2.5mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine sulfate tab 20mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine sulfate tab 30mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine sulfate tab 7.5mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DHIVY TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
DIABETIC METER (all other diabetic meters)	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
DIACOMIT CAP (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B	ANTICONVULSANTS
DIACOMIT POWDER PACK (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B	ANTICONVULSANTS
DIALYVITE TAB	-	G	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	-	G	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	G	MULTIVITAMINS
DIAPHRAGM	-	\$0	MEDICAL DEVICES AND SUPPLIES
DIASTAT ACDL GEL (QL= 2 packs/fill)	QL	B	ANTICONVULSANTS
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 2 packs/fill)	QL	B	ANTICONVULSANTS
diazepam conc (VALIUM equiv)	-	G	ANTIANKXIETY AGENTS
DIAZEPAM GEL (QL= 2 packs/fill)	QL	B	ANTICONVULSANTS
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	G	ANTIANKXIETY AGENTS
diazepam rectal gel (QL= 2 packs/fill)	QL	G	ANTICONVULSANTS
diazepam tab (VALIUM equiv)	-	G	ANTIANKXIETY AGENTS
diazoxide susp (PROGLYCEM equiv)	-	G	ANTIDIABETICS
dichlorphenamide tab (KEVEYIS equiv)	-	NC	DIURETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
DICLOFENAC CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	G	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	G	DERMATOLOGICALS
DICLOFENAC PATCH, FLECTOR PATCH (QL= 30 patches/fill; Step Therapy requires trial of celecoxib)	QL-ST	B	DERMATOLOGICALS
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	NC	MIGRAINE PRODUCTS
diclofenac potassium cap (ZIPSOR equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
diclofenac potassium tab (CATAFLAM equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac potassium tab 25mg (DICLOFENAC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium EC tab (VOLTAREN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium gel kit (VENNGEL equiv)	-	NC	DERMATOLOGICALS
diclofenac sodium ophth soln (VOLTAREN equiv)	-	G	OPHTHALMIC AGENTS
diclofenac sodium soln (XRYLIX equiv)	-	NC	DERMATOLOGICALS
diclofenac sodium soln 2% (PENNSAID SOLN equiv)	-	NC	DERMATOLOGICALS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac soln 1.5% (PENNSAID equiv)	-	G	DERMATOLOGICALS
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
DICLONA GEL	-	NC	DERMATOLOGICALS
DICLOTREX PAK	-	NC	DERMATOLOGICALS
dicloxacillin cap (DYNAPEN equiv)	-	G	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	G	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	G	ULCER DRUGS
dicyclomine tab (BENTYL equiv)	-	G	ULCER DRUGS
didanosine DR cap (VIDEX EC equiv)	-	G	ANTIVIRALS
DIDANOSINE DR CAP, VIDEX EC CAP	-	G	ANTIVIRALS
DIETHYLPROPION ER TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
diethylpropion tab	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DIFFERIN OTC GEL 0.1%	OTC	EXC	DERMATOLOGICALS
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	B	MACROLIDES
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	B	MACROLIDES
DIFLORASONE CREAM, PSORCON CREAM	-	NC	DERMATOLOGICALS
diflorasone oint	-	NC	DERMATOLOGICALS
diflunisal tab (DOLOBID equiv)	-	G	ANALGESICS - NONNARCOTIC
difluprednate ophth emulsion (DUREZOL equiv)	-	G	OPHTHALMIC AGENTS
digoxin soln (LANOXIN equiv)	-	G	CARDIOTONICS
DIGOXIN SOLN 0.05MG/ML	-	G	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	G	CARDIOTONICS
digoxin tab 62.5mcg (LANOXIN equiv)	-	NC	CARDIOTONICS
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC	MIGRAINE PRODUCTS
dihydroergotamine mesylate nasal spray (MIGRANAL equiv) (QL= 8 sprays/fill, 2 fills/30 days)	PA-QL	G	MIGRAINE PRODUCTS
DILANTIN CAP 30MG	-	B	ANTICONVULSANTS
diltiazem ER cap (CARDIZEM CD equiv)	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (DILACOR XR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	G	CALCIUM CHANNEL BLOCKERS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
diltiazem ER cap 120mg (CARDIZEM SR equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
DILTIAZEM HCL COATED BEADS CAP ER 24HR 120MG	-	G	CALCIUM CHANNEL BLOCKERS
DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 120MG	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	G	CALCIUM CHANNEL BLOCKERS
dimethyl fumarate DR cap (TECFIDERA equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIOVAN TAB	-	NC	ANTIHYPERTENSIVES
DIPENTUM CAP	-	B	GASTROINTESTINAL AGENTS - MISC.
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	G	ANTIHISTAMINES
DIPHENOXYLATE/ATROPINE LIQUID	-	B	ANTIDIARRHEAL/PROBIOTIC AGENTS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	G	ANTIDIARRHEALS
DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	\$0	TOXOIDS
dipyridamole tab (PERSANTINE equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	G	ANTIARRHYTHMICS
disopyramide ER cap (NORPACE CR equiv)	-	G	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIURIL SUSP	-	B	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	G	ANTICONVULSANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	G	ANTICONVULSANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	G	ANTICONVULSANTS
DIVIGEL GEL	-	NC	ESTROGENS
DIVIGEL GEL, ELESTRIN GEL	-	NC	ESTROGENS
dofetilide cap (TIKOSYN equiv)	-	G	ANTIARRHYTHMICS
DOJOLVI ORAL LIQUID	-	NC	NUTRIENTS
DOLGIC PLUS TAB	-	NC	ANALGESICS - NONNARCOTIC
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day)	QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DONNATAL TAB	-	NC	ULCER DRUGS
DOPTLET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
DORAL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
DORYX MPC TAB	-	NC	TETRACYCLINES
dorzolamide ophth soln (TRUSOPT equiv)	-	G	OPHTHALMIC AGENTS
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	G	OPHTHALMIC AGENTS
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
DOVATO TAB	-	B	ANTIVIRALS
doxazosin tab (CARDURA equiv)	-	G	ANTIHYPERTENSIVES
doxepin cap (SINEQUAN equiv)	-	G	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	G	ANTIDEPRESSANTS
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	-	NC	DERMATOLOGICALS
DOXEPIN HCL CREAM	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
doxepin tab (SILENOR equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
doxercalciferol cap (HECTOROL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
DOXYCYCLINE CAP, ORACEA CAP	-	NC	DERMATOLOGICALS
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	G	TETRACYCLINES
doxycycline hyclate DR tab (DORYX equiv)	-	NC	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	G	TETRACYCLINES
doxycycline hyclate tab (TARGADOX equiv)	-	NC	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg	-	NC	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv)	-	G	TETRACYCLINES
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv)	-	G	TETRACYCLINES
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate tab 75mg (ADOXA equiv)	-	NC	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	G	TETRACYCLINES
doxylamine/pyridoxine dr tab (DICLEGIS equiv)	-	NC	ANTIEMETICS
D-PENAMINE TAB	-	B	ASSORTED CLASSES
DRIZALMA DR CAP	-	NC	ANTIDEPRESSANTS
dronabinol cap (MARINOL equiv)	PA	G	ANTIEMETICS
drosiprone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	NC	CONTRACEPTIVES
DROXIA CAP	-	B	HEMATOPOIETIC AGENTS
droxidopa cap (NORTHERA equiv)	-	NC	VASOPRESSORS
DRYSOL SOLN	-	G	DERMATOLOGICALS
DSUVIA SL TAB	-	NC	ANALGESICS - OPIOID
DUAKLIR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
DUAVEE TAB	-	B	ESTROGENS
DUET	-	NC	MULTIVITAMINS
DUET DHA 400, DUET DHA BALANCED	-	NC	MULTIVITAMINS
DUETACT TAB	-	NC	ANTIDIABETICS
DULERA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
duloxetine cap 40mg (IRENKA equiv)	-	NC	ANTIDEPRESSANTS
duloxetine EC cap (CYMBALTA equiv)	-	G	ANTIDEPRESSANTS
DULOXICAININE PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DUOBRII LOTION	-	NC	DERMATOLOGICALS
DUOPA ENTERAL SUSP	-	NC	ANTIPARKINSON AGENTS
DUOVISC KIT	-	NC	OPHTHALMIC AGENTS
DUPIXENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
DUPIXENT PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
DURAVENT PE TAB	-	NC	COUGH/COLD/ALLERGY
DUROLANE INJ	LMSP-PA	B	MUSCULOSKELETAL THERAPY AGENTS
dutasteride cap (AVODART equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
dutasteride/tamsulosin cap (JALYN equiv)	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
DUTOPROL TAB	-	NC	ANTIHYPERTENSIVES
DUZALLO TAB	-	NC	GOUT AGENTS
DXEVO 11-DAY PAK	-	NC	CORTICOSTEROIDS
DYANAVEL XR CHEW	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DYRENIUM CAP	-	B	DIURETICS
DYSPORT INJ	MSP-PA	B	NEUROMUSCULAR AGENTS
EB-N3 DR CAP	-	NC	MULTIVITAMINS
ECONASIL KIT	-	NC	DERMATOLOGICALS
econazole cream (SPECTAZOLE equiv) (QL= 30gm/30 days)	QL	G	DERMATOLOGICALS
ECOZA FOAM	-	NC	DERMATOLOGICALS
EDARBI TAB	-	NC	ANTIHYPERTENSIVES
EDARBYCLOR TAB	-	NC	ANTIHYPERTENSIVES
EDECRIN TAB	-	NC	DIURETICS
EDEX INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B	CARDIOVASCULAR AGENTS - MISC.
EDLUAR SL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
EDURANT TAB	-	B	ANTIVIRALS
EFAVIRENZ CAP	-	G	ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	G	ANTIVIRALS
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	G	ANTIVIRALS
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	G	ANTIVIRALS
EFFEXOR XR CAP	-	NC	ANTIDEPRESSANTS
EGATEN TAB	-	NC	ANTHELMINTICS
EGRIFTA INJ	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ELAPRASE INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ELEPSIA XR TAB	-	NC	ANTICONVULSANTS
eletriptan tab (RELPAK equiv)	-	NC	MIGRAINE PRODUCTS
ELIGEN B12 TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ELIQUIS TAB, ELIQUIS STARTER PACK	-	B	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	\$0	CONTRACEPTIVES
ELMIRON CAP	-	B	GENITOURINARY AGENTS - MISCELLANEOUS
eluryng vaginal ring (NUVARING equiv)	-	NC	CONTRACEPTIVES
ELYXYB SOLN	-	NC	MIGRAINE PRODUCTS
EMADINE OPPTH SOLN	-	NC	OPHTHALMIC AGENTS
EMBEDA CAP	-	NC	ANALGESICS - OPIOID
EMCYT CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMEND CAP	-	NC	ANTIEMETICS
EMEND SUSP	-	NC	ANTIEMETICS
EMFLAZA SUSP	-	NC	CORTICOSTEROIDS
EMFLAZA TAB	-	NC	CORTICOSTEROIDS
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	B	MIGRAINE PRODUCTS
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
EMSAM PATCH	-	B	ANTIDEPRESSANTS
emtricitabine cap (EMTRIVA equiv)	-	G	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	\$0	ANTIVIRALS
EMTRIVA CAP	-	B	ANTIVIRALS
EMTRIVA SOLN	-	B	ANTIVIRALS
EMVERM TAB	-	NC	ANTHELMINTICS
enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for members age 9 or older)	PA	G	ANTIHYPERTENSIVES
enalapril tab (VASOTEC equiv)	-	G	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	G	ANTIHYPERTENSIVES
ENBRACE HR	-	NC	MULTIVITAMINS
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENDARI POWDER PACK (QL= 6 packets/day)	LMSP-PA-QL	B	HEMATOPOIETIC AGENTS
ENDOMETRIN INSERT	PA	B	VAGINAL PRODUCTS
ENGERIX-B/RECOMBIVAX-HB INJ	VAC	\$0	VACCINES
enoxaparin inj (LOVENOX equiv)	-	G	ANTICOAGULANTS
enpresse tab (TRI-LEVELLEN equiv)	-	\$0	CONTRACEPTIVES
ENSPRYNG INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
ENSTILAR FOAM	-	NC	DERMATOLOGICALS
entacapone tab (COMTAN equiv)	-	G	ANTIPARKINSON AGENTS
ENTADFI CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	G	ANTIVIRALS
ENTEREG CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ENTRESTO TAB (QL= 2 tabs/day)	QL	B	CARDIOVASCULAR AGENTS - MISC.
ENTYVIO INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
ENVARUSUS XR TAB	-	NC	ASSORTED CLASSES
EOHILIA SUSP	-	NC	CORTICOSTEROIDS
EPCLUSA PAK	-	NC	ANTIVIRALS
EPCLUSA TAB	-	NC	ANTIVIRALS
EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553)	LD-PA	B	ANTICONVULSANTS
EPIDUO FORTE GEL 0.3-2.5%	-	NC	DERMATOLOGICALS
EPIDUO GEL 0.1-2.5%	-	NC	DERMATOLOGICALS
EPIFOAM AEROSOL	-	B	DERMATOLOGICALS
epinastine ophth soln (ELESTAT equiv)	-	G	OPHTHALMIC AGENTS
epinephrine hcl nasal soln (ADRENALIN equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	G	VASOPRESSORS
EPIPEN (JR) INJ	-	NC	VASOPRESSORS
EPIQUIN MICRO CREAM	-	NC	DERMATOLOGICALS
EPIVIR HBV SOLN	-	B	ANTIVIRALS
eplerenone tab (INSPIRA equiv)	-	G	ANTIHYPERTENSIVES
EPOGEN INJ	-	NC	HEMATOPOIETIC AGENTS
EPRONTIA SOLN (Members age 9 or older require Prior Authorization)	PA	B	ANTICONVULSANTS
EPSOLAY CREAM	-	NC	DERMATOLOGICALS
EQUETRO CAP	-	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ERGOAL CAP	-	NC	VITAMINS
ERGOLOID MESYLATES TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ergotamine/cafeine tab (CAFERGOT equiv)	-	NC	MIGRAINE PRODUCTS
ERIVEDGE CAP	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB (QL= 4 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB 240MG (QL= 1 tab/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab (TARCEVA equiv) (QL= 1 tab/day)	LMSP-PA-QL-SF	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab 25mg (TARCEVA equiv) (QL= 3 tabs/day)	LMSP-PA-QL-SF	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERMEZA SOLN 150 MCG/5ML	-	NC	THYROID AGENTS
ERTACZO CREAM	-	NC	DERMATOLOGICALS
ERY PAD	-	NC	DERMATOLOGICALS
ERYPED SUSP	-	NC	MACROLIDES
erythromycin DR cap (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	G	MACROLIDES
ERYTHROMYCIN EC CAP (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	B	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv) (Step Therapy requires trial of azithromycin or clarithromycin)	ST	G	MACROLIDES
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	NC	MACROLIDES
erythromycin gel	-	G	DERMATOLOGICALS
erythromycin ophth oint	-	G	OPHTHALMIC AGENTS
ERYTHROMYCIN OPHTH OINT	-	NC	OPHTHALMIC AGENTS
erythromycin pad	-	G	DERMATOLOGICALS
erythromycin soln	-	G	DERMATOLOGICALS
erythromycin tab (ERY-TAB equiv) (Step Therapy requires trial of azithromycin, clarithromycin or doxycycline hyclate 100mg)	ST	G	MACROLIDES
erythromycin tab (ERYTHROMYCIN equiv) (Step Therapy require trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	G	MACROLIDES
erythromycin/benzoyl peroxide gel	-	G	DERMATOLOGICALS
ESBRIET CAP	-	NC	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 267MG	-	NC	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 801MG	-	NC	RESPIRATORY AGENTS - MISC.
escitalopram soln (LEXAPRO equiv)	-	G	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	G	ANTIDEPRESSANTS
ESKATA SOLN	-	NC	DERMATOLOGICALS
esomeprazole cap (NEXIUM equiv) (Rx Only)	PA	G	ULCER DRUGS
esomeprazole DR granule pack (NEXIUM equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
esomeprazole magnesium DR tab (NEXIUM equiv)	OTC	EXC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
estazolam tab (PROSOM equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	G	ESTROGENS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ESTRACE VAGINAL CREAM	-	NC	VAGINAL PRODUCTS
estradiol cream (ESTRACE equiv)	-	NC	VAGINAL PRODUCTS
estradiol patch (CLIMARA equiv)	-	G	ESTROGENS
estradiol patch (VIVELLE-DOT equiv)	-	G	ESTROGENS
estradiol tab (ESTRACE equiv)	-	G	ESTROGENS
estradiol td gel (DIVIGEL equiv)	-	NC	ESTROGENS
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill)	QL	G	VAGINAL PRODUCTS
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	G	ESTROGENS
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	G	ESTROGENS
ESTRING (3 copays per Rx)	-	B	VAGINAL PRODUCTS
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ethacrynic tab (EDECIN equiv)	-	NC	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	G	ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	G	ANTICONVULSANTS
etodolac cap (LODINE equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	G	ANALGESICS - ANTI-INFLAMMATORY
ETOPOSIDE CAP	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
etravirine tab (INTELENCE equiv)	-	G	ANTIVIRALS
EUCRISA OINT	-	NC	DERMATOLOGICALS
EULEXIN CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EVAMIST SPRAY	-	NC	ESTROGENS
EVEKEO ODT	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab (ZORTRESS equiv)	LMSP-PA-QL	G	MISCELLANEOUS THERAPEUTIC CLASSES
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	LMSP-PA-QL-SF	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EVIVO LIQUID	-	NC	ANTIDIARRHEALS
EVOCLIN FOAM	-	NC	DERMATOLOGICALS
EVOTAZ TAB	-	B	ANTIVIRALS
EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
EVZIO INJ	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
EVZIO INJ	-	NC	ANTIDOTES
EXALGO TAB	-	NC	ANALGESICS - OPIOID
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC	DERMATOLOGICALS
EXELDERM SOLN	-	NC	DERMATOLOGICALS
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC	DERMATOLOGICALS
exemestane tab (AROMASIN equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXSERVAN FILM	-	NC	NEUROMUSCULAR AGENTS
EXTAVIA INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EYSUVIS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
EZALLOR SPRINKLE CAP (Prior Authorization Required for members age 9 years and older)	PA	B	ANTIHYPERLIPIDEMICS
ezetimibe tab (ZETIA equiv)	-	G	ANTIHYPERLIPIDEMICS
EZETIMIBE/ATORVASTATIN TAB	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (This strength excluded from coverage)	-	NC	ANTIHYPERLIPIDEMICS
FABHALTA CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
FABIOR AEROSOL FOAM	-	NC	DERMATOLOGICALS
FABRAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
FACTIVE TAB	-	NC	FLUOROQUINOLONES
FALESSA KIT	-	NC	CONTRACEPTIVES
FALESSA TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
famciclovir tab (FAMVIR equiv)	-	G	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	G	ULCER DRUGS
famotidine tab (PEPCID equiv) (Rx Only)	-	G	ULCER DRUGS
FANAPT TAB (QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANAPT TITRATION PACK (QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FARXIGA TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS
FASENRA PEN INJ (QL= 1 inj/56 days; Only available through Accredited 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST-¢	G	GOUT AGENTS
FEIBA INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
felbamate susp (FELBATOL equiv)	-	G	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	G	ANTICONVULSANTS
FELBATOL TAB	-	NC	ANTICONVULSANTS
felodipine ER tab (PLENDIL equiv)	-	G	CALCIUM CHANNEL BLOCKERS
FEM PH GEL	-	B	VAGINAL PRODUCTS
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$0	MEDICAL DEVICES AND SUPPLIES
FEMHRT TAB	-	NC	ESTROGENS
FEMRING (3 copays per Rx)	-	B	VAGINAL PRODUCTS
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	G	ANTIHYPERLIPIDEMICS
FENOFIBRATE CAP, LIPOFEN CAP	-	NC	ANTIHYPERLIPIDEMICS
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	G	ANTIHYPERLIPIDEMICS
fenofibric acid DR cap (TRILIPIX equiv)	-	G	ANTIHYPERLIPIDEMICS
FENOFIBRIC TAB, FIBRICOR TAB	-	NC	ANTIHYPERLIPIDEMICS
fenopropfen calcium cap (NALFON equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
fenopropfen calcium tab	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
fantanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	G	ANALGESICS - OPIOID
fantanyl patch (DURAGESIC equiv)	-	G	ANALGESICS - OPIOID
fantanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
FENTORA TAB, FENTANYL BUCCAL TAB (QL= 120 tabs/30 days)	PA-QL	B	ANALGESICS - OPIOID
FEONYX TAB	-	NC	HEMATOPOIETIC AGENTS
ferrex 150 forte cap	-	G	HEMATOPOIETIC AGENTS
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B	ANTIDOTES
FERRIPROX TAB 1000MG (TWICE DAILY)	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
FERRO-PLEX TAB	-	NC	HEMATOPOIETIC AGENTS
ferrous sulfate elixir	OTC	NC	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID	OTC	NC	HEMATOPOIETIC AGENTS
ferrous sulfate soln	OTC	NC	HEMATOPOIETIC AGENTS
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	NC	URINARY ANTISPASMODICS
FETZIMA CAP	-	NC	ANTIDEPRESSANTS
FETZIMA TITRATION PACK	-	NC	ANTIDEPRESSANTS
FIASP FLEXTOUCH INJ	-	NC	ANTIDIABETICS
FIASP INJ	-	NC	ANTIDIABETICS
FIASP PENFILL INJ, FIASP PUMP CARTRIDGE	-	NC	ANTIDIABETICS
FIBRIK CAP	-	NC	MULTIVITAMINS
FILSPARI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	GENITOURINARY AGENTS - MISCELLANEOUS
FILSUVEZ GEL	-	NC	DERMATOLOGICALS
FINACEA FOAM	-	B	DERMATOLOGICALS
finasteride tab (PROPECIA equiv)	-	EXC	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
fingolimod hcl cap 0.5mg (GILENYA equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ANTICONVULSANTS
FIRAZYR INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	B	ANTIMYASTHENIC/CHOLINERGIC AGENTS
FIRMAGON INJ	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FIRST METRONIDAZOLE SUSP	-	B	ANTI-INFECTIVE AGENTS - MISC.
FIRST MOUTHWASH BLM	-	B	MOUTH/THROAT/DENTAL AGENTS
FIRST OMEPRAZOLE SUSP	PA	B	ULCER DRUGS
FIRST PANTOPRAZOLE SUSP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS
FIRVANQ SOLN	-	G	ANTI-INFECTIVE AGENTS - MISC.
FIRVANQ SOLN 50MG/ML	-	G	ANTI-INFECTIVE AGENTS - MISC.
FLAREX OPHTH SUSP	-	B	OPHTHALMIC AGENTS
flavoxate tab (URISPAS equiv)	-	G	URINARY ANTISPASMODICS
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
flecainide tab (TAMBOCOR equiv)	-	G	ANTIARRHYTHMICS
FLEQSUVY SUSP (Prior Authorization required for members age 9 or older)	PA	B	MUSCULOSKELETAL THERAPY AGENTS
FLOLIPID SUSP (Members age 9 or older require Prior Authorization)	PA	B	ANTIHYPERLIPIDEMICS
FLONASE SENSIMIST NASAL SPRAY	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
FLO-PRED SUSP	-	NC	CORTICOSTEROIDS
FLORIVA CHEW TAB	-	NC	MULTIVITAMINS
FLORIVA PLUS DROPS	-	B	MULTIVITAMINS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
FLOVENT DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLOVENT HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
FLUAD QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
FLUBLOK QUAD PF INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
FLUCELVAX QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
fluconazole susp (DIFLUCAN equiv)	-	G	ANTIFUNGALS
fluconazole tab (DIFLUCAN equiv)	-	G	ANTIFUNGALS
flucytosine cap (ANCOBON equiv)	-	G	ANTIFUNGALS
fludrocortisone tab (FLORINEF equiv)	-	G	CORTICOSTEROIDS
FLULAVAL QUAD INJ, FLUZONE QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
FLUMIST QUADRIVALENT NASAL SUSP (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
flunisolide nasal soln	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
FLUOCINOLONE ACET CREAM	-	G	DERMATOLOGICALS
fluocinolone acetonide cream	-	G	DERMATOLOGICALS
fluocinolone acetonide oil	-	G	DERMATOLOGICALS
fluocinolone acetonide oint	-	G	DERMATOLOGICALS
fluocinolone acetonide soln	-	G	DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	G	OTIC AGENTS
fluocinonide cream 0.05% (LIDEX equiv)	-	G	DERMATOLOGICALS
fluocinonide cream 0.1%	-	NC	DERMATOLOGICALS
fluocinonide emollient cream	-	G	DERMATOLOGICALS
fluocinonide gel	-	G	DERMATOLOGICALS
fluocinonide oint	-	G	DERMATOLOGICALS
fluocinonide soln	-	G	DERMATOLOGICALS
FLUOPAR KIT	-	NC	DERMATOLOGICALS
FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
FLUORAC CREAM	-	NC	DERMATOLOGICALS
FLUORIDEX SENSITIVITY PASTE	-	G	MOUTH/THROAT/DENTAL AGENTS
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	G	OPHTHALMIC AGENTS
FLUOROPLEX CREAM	-	NC	DERMATOLOGICALS
fluorouracil cream (EFUDEX CREAM equiv)	-	G	DERMATOLOGICALS
FLUOROURACIL CREAM 0.5%	-	NC	DERMATOLOGICALS
FLUOROURACIL SOLN	-	B	DERMATOLOGICALS
FLUOVIX PAK	-	NC	DERMATOLOGICALS
fluoxetine cap (PROZAC equiv)	-	G	ANTIDEPRESSANTS
FLUOXETINE CAP (PMDD)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
fluoxetine soln (PROZAC equiv)	-	G	ANTIDEPRESSANTS
fluoxetine tab (PROZAC equiv)	-	G	ANTIDEPRESSANTS
FLUOXETINE TAB 60MG	-	NC	ANTIDEPRESSANTS
fluoxetine weekly cap (PROZAC equiv)	-	NC	ANTIDEPRESSANTS
fluphenazine tab (PROLIXIN equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
flurandrenolide cream (CORDRAN equiv)	-	NC	DERMATOLOGICALS
flurandrenolide lotion (CORDRAN equiv)	-	NC	DERMATOLOGICALS
flurandrenolide oint (CORDRAN equiv)	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
FLURAZEPAM CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
FLURBIPROFEN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
FLURBIPROFEN TAB	-	G	ANALGESICS - ANTI-INFLAMMATORY
flurbiprofen tab (ANSAID equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
FLUTAMIDE CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
flutamide cap (EULEXIN equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FLUTICASONE DISKUS INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE HFA INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE LOTION	-	NC	DERMATOLOGICALS
fluticasone nasal spray (FLONASE equiv)	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	G	DERMATOLOGICALS
FLUTICASONE PROPIONATE DISKUS INHALER 100MCG/ACT	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE PROPIONATE DISKUS INHALER 250MCG/ACT	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE PROPIONATE DISKUS INHALER 50MCG/ACT	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone propionate lotion (CUTIVATE equiv)	-	NC	DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	G	DERMATOLOGICALS
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 115-21 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 230-21 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 45-21 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvastatin cap (LESCOL equiv)	-	NC	ANTIHYPERLIPIDEMICS
fluvastatin ER tab (LESCOL XL equiv)	-	NC	ANTIHYPERLIPIDEMICS
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	G	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	G	ANTIDEPRESSANTS
FLUZONE HD PF INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
FLUZONE/FLUARIX QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0	VACCINES
FML FORTE OPHTH SUSP	-	B	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
FML S.O.P. OPHTH OINT	-	B	OPHTHALMIC AGENTS
FOCALIN XR CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
FOLAGENT DHA CAP	-	NC	MULTIVITAMINS
FOLAMED DHA CAP	-	NC	MULTIVITAMINS
FOLBEE PLUS CZ TAB	-	G	MULTIVITAMINS
folbee tab	-	G	HEMATOPOIETIC AGENTS
FOLET ONE	-	NC	MULTIVITAMINS
folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0	HEMATOPOIETIC AGENTS
folic acid tab 400mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
folic acid tab 800mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
FOLIKA-V TAB	-	NC	MULTIVITAMINS
FOLITE TAB	-	NC	HEMATOPOIETIC AGENTS
FOLTANX TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
folvite-d tab (GENICIN VITA-D equiv)	-	NC	HEMATOPOIETIC AGENTS
FOLVITE-FE TAB	-	NC	HEMATOPOIETIC AGENTS
fondaparinux inj (ARIXTRA equiv)	-	G	ANTICOAGULANTS
FORFIVO XL TAB	-	NC	ANTIDEPRESSANTS
formoterol fumarate neb soln (PERFOROMIST equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FORTAMET TAB	-	NC	ANTIDIABETICS
FORTEO INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FORTICAL NASAL SPRAY	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX+D TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosamprenavir tab (LEXIVA equiv)	-	G	ANTIVIRALS
fosfomycin tromethamine powder pack (MONUROL equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
fosinopril tab (MONOPRIL equiv)	-	G	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	G	ANTIHYPERTENSIVES
FOSRENOL CHEW TAB	-	B	GASTROINTESTINAL AGENTS - MISC.
FOSRENOL POWDER PACK	-	B	GASTROINTESTINAL AGENTS - MISC.
FOTIVDA CAP (QL= 21 caps/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FRAGMIN INJ	-	B	ANTICOAGULANTS
FREESTYLE FREEDOM LITE METER	OTC	NC	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX METER	OTC	NC	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX TEST STRIP	OTC	NC	DIAGNOSTIC PRODUCTS
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 READER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE METER	OTC	NC	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP	OTC	NC	DIAGNOSTIC PRODUCTS
FREESTYLE PRECISION NEO METER	OTC	NC	MEDICAL DEVICES AND SUPPLIES
FREESTYLE PRECISION NEO TEST STRIP	OTC	NC	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP	OTC	NC	DIAGNOSTIC PRODUCTS
FROVA TAB	-	NC	MIGRAINE PRODUCTS
frovatriptan tab (FROVA equiv)	-	NC	MIGRAINE PRODUCTS
FRUZAQLA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FULPHILA INJ	LMSP	B	HEMATOPOIETIC AGENTS
FUROSCIX KIT (QL= 8 inj/fill; Only available through BioMatrix Specialty Pharmacy 855-359-9679)	LD-QL	B	DIURETICS
FUROSEMIDE SOLN	-	G	DIURETICS
furosemide soln (LASIX equiv)	-	G	DIURETICS
furosemide tab (LASIX equiv)	-	G	DIURETICS
FUZEON INJ	LMSP	B	ANTIVIRALS
FYCOMPA TAB	-	B	ANTICONSULSANTS
FYCOMPA SUSP	-	B	ANTICONSULSANTS
FYLNETRA INJ	-	NC	HEMATOPOIETIC AGENTS
gabapentin (once-daily) tab (GRALISE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
gabapentin cap 100mg (NEURONTIN equiv) (QL= 9 caps/day)	QL	G	ANTICONSULSANTS
gabapentin cap 300mg (NEURONTIN equiv) (QL= 6 caps/day)	QL	G	ANTICONSULSANTS
gabapentin cap 400mg (NEURONTIN equiv) (QL= 4 caps/day)	QL	G	ANTICONSULSANTS
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	G	ANTICONSULSANTS
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	G	ANTICONSULSANTS
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	G	ANTICONSULSANTS
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
GALAFOLD CAP (QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
galantamine ER cap (RAZADYNE ER equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALANTAMINE SOLN	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
galantamine tab (RAZADYNE equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALZIN CAP	-	B	MINERALS & ELECTROLYTES
GAMASTAN S/D INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
GAMUNEX INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
GANCICLOVIR INJ	MSP	B	ANTIVIRALS
ganciclovir inj (CYTOVENE equiv)	MSP	B	ANTIVIRALS
ganirelix ac inj (GANIRELIX equiv)	INF-MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
GARDASIL 9 INJ	VAC	\$0	VACCINES
gatifloxacin ophth soln (ZYMAXID equiv)	-	G	OPHTHALMIC AGENTS
GATTEX KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
GAVILYTE-C SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
GAVRETO CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GEAMETDRAY GEL	-	NC	DERMATOLOGICALS
gefitinib tab (IRESSA equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GELCLAIR GEL	-	B	MOUTH/THROAT/DENTAL AGENTS
GELNIQUE	-	NC	URINARY ANTISPASMODICS
gemfibrozil tab (LOPID equiv)	-	G	ANTHYPERLIPIDEMICS
GEMTESA TAB	-	NC	URINARY ANTISPASMODICS
GEN7T LOTION	-	NC	DERMATOLOGICALS
GEN7T PAD 3.5%	-	NC	DERMATOLOGICALS
GEN7T PLUS LOTION	-	NC	DERMATOLOGICALS
GEN7T PLUS PAD	-	NC	DERMATOLOGICALS
GENOTROPIN INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENTAK OPHTH OINT	-	G	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	G	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	G	DERMATOLOGICALS
gentamicin sulfate oint	-	G	DERMATOLOGICALS
GENVISC 850 INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
GENVOYA TAB	-	B	ANTIVIRALS
GIALAX KIT	-	NC	LAXATIVES
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0	CONTRACEPTIVES
GILENYA CAP 0.25MG	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILENYA CAP 0.5MG	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GIMOTI NASAL SPRAY	-	NC	GASTROINTESTINAL AGENTS - MISC.
GLASSIA INJ	MSP-PA	B	RESPIRATORY AGENTS - MISC.
glatiramer inj (COPAXONE equiv)	LMSP-PA	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GLEOSTINE/LOMUSTINE CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	G	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	G	ANTIDIABETICS
glipizide tab (GLUCOTROL equiv)	-	G	ANTIDIABETICS
GLIPIZIDE TAB	-	NC	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	G	ANTIDIABETICS
GLOPERBA SOLN (Prior Authorization required for members age 9 or older)	PA	B	GOUT AGENTS
GLUCAGEN HYPOKIT INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUCAGEN INJ	-	B	DIAGNOSTIC PRODUCTS
GLUCAGON DIAGNOSTIC INJ	-	NC	DIAGNOSTIC PRODUCTS
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUCAGON KIT (QL= 2 inj/fill)	QL	G	ANTIDIABETICS
GLUMETZA TAB 1000MG	-	NC	ANTIDIABETICS
GLUMETZA TAB 500MG	-	NC	ANTIDIABETICS
GLYBURID MCR TAB	-	G	ANTIDIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
glyburide tab (MICRONASE equiv)	-	G	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	G	ANTIDIABETICS
GLYCATE TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC	ULCER DRUGS
glycopyrrolate oral soln (CUVPOSA equiv)	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
glycopyrrolate tab (ROBINUL equiv)	-	G	ULCER DRUGS
GLYGEST PAK	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
GLYXAMBI TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS
GOCOVRI CAP	-	NC	ANTIPARKINSON AGENTS
GOLYTELY SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES
GONITRO POWDER	-	NC	ANTIANGINAL AGENTS
GRALISE STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GRALISE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	G	ANTIEMETICS
GRANISOL SOLN (QL= 60ml/fill)	QL	B	ANTIEMETICS
GRANIX INJ	-	NC	HEMATOPOIETIC AGENTS
GRASTEK SL TAB	-	NC	BIOLOGICALS MISC
griseofulvin micro tab (GRIFULVIN V equiv)	-	G	ANTIFUNGALS
griseofulvin susp (GRIFULVIN equiv)	-	G	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	G	ANTIFUNGALS
GUAIFENESEN SYRUP	-	NC	COUGH/COLD/ALLERGY
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	G	COUGH/COLD/ALLERGY
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	G	COUGH/COLD/ALLERGY
guaifenesin-DM oral liquid (ROBITUSSIN equiv)	-	NC	COUGH/COLD/ALLERGY
guanfacine ER tab (INTUNIV equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
guanfacine IR tab (TENEX equiv)	-	G	ANTIHYPERTENSIVES
GVOKE INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GVOKE INJ KIT (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GVOKE PFS INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
HADLIMA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HAEGARDA INJ (Only available through Accredo 800-803-2523)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
halcinonide cream (HALOG equiv)	-	NC	DERMATOLOGICALS
HALOBETASOL AER	-	NC	DERMATOLOGICALS
halobetasol propionate cream (ULTRAVATE equiv)	-	G	DERMATOLOGICALS
halobetasol propionate foam (HALOBETASOL equiv)	-	NC	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv)	-	G	DERMATOLOGICALS
HALOG CREAM	-	NC	DERMATOLOGICALS
HALOG OINT	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
HALOG SOLN	-	NC	DERMATOLOGICALS
halonate pac kit (ULTRAVATE KIT equiv)	-	NC	DERMATOLOGICALS
haloperidol lactate conc (HALDOL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
haloperidol tab (HALDOL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
HARVONI PELLETT PAK	-	NC	ANTIVIRALS
HARVONI TAB	-	NC	ANTIVIRALS
HAVRIX INJ, VAQTA INJ	VAC	\$0	VACCINES
HC BUTYRATE CREAM	-	NC	DERMATOLOGICALS
HC BUTYRATE SOLN	-	NC	DERMATOLOGICALS
HC/PRAMOXINE CREAM 1-2.35%	-	NC	DERMATOLOGICALS
HC-LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
HELIDAC PACK	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
HELIXATE/KOGENATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HEMANGEOL SOLN	-	NC	BETA BLOCKERS
HEMLIBRA INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HEPLISAV-B INJ	VAC	\$0	VACCINES
HERCEPTIN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HETLIOZ CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
HETLIOZ SUSP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
HEXALEN CAP	-	B	ANTINEOPLASTICS
HIXDEFRIMA SOLN	-	NC	DERMATOLOGICALS
HIZENTRA INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
HOMATROPINE OPTH SOLN	-	B	OPHTHALMIC AGENTS
HORIZANT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
HULIO INJ (adalimumab fkjp)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HULIO KIT (adalimumab-fkjp)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMALOG JR KWIKPEN INJ	-	B	ANTIDIABETICS
HUMALOG KWIKPEN INJ	-	B	ANTIDIABETICS
HUMALOG MIX INJ	-	B	ANTIDIABETICS
HUMALOG MIX KWIKPEN INJ	-	B	ANTIDIABETICS
HUMALOG PEN INJ	-	B	ANTIDIABETICS
HUMATE-P/WILATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HUMATIN CAP	-	NC	AMINOGLYCOSIDES
HUMATROPE INJ, ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 80MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC UC STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN MIX INJ	OTC	B	ANTIDIABETICS
HUMULIN MIX PEN INJ	OTC	B	ANTIDIABETICS
HUMULIN N INJ	OTC	B	ANTIDIABETICS
HUMULIN N PEN INJ	OTC	B	ANTIDIABETICS
HUMULIN R INJ	OTC	B	ANTIDIABETICS
HUMULIN R INJ U-500	-	B	ANTIDIABETICS
HUMULIN R U-500 KWIKPEN INJ	-	B	ANTIDIABETICS
HURRISEAL MIS SNAP	-	NC	MEDICAL DEVICES AND SUPPLIES
HYALGAN INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
HYCAMTIN CAP	LMSP-PA	B	ANTINEOPLASTICS
HYCLODEX SOLN	-	NC	DERMATOLOGICALS
HYCODAN SYRUP	-	B	COUGH/COLD/ALLERGY
HYCOFENIX SOLN	-	NC	COUGH/COLD/ALLERGY
HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	G	COUGH/COLD/ALLERGY
hydralazine tab (APRESOLINE equiv)	-	G	ANTIHYPERTENSIVES
hydrochlorothiazide cap (MICROZIDE equiv)	-	G	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	G	DIURETICS
HYDROCODONE BITARTRATE ER CAP (QL= 2 caps/day)	QL	B	ANALGESICS - OPIOID
hydrocodone bitartrate ER cap (ZOHYDRO equiv) (QL= 2 caps/day)	QL	G	ANALGESICS - OPIOID
hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day)	QL	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen cap (LORCET equiv)	-	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab (LORTAB equiv)	-	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	G	COUGH/COLD/ALLERGY
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	QL	G	COUGH/COLD/ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	G	COUGH/COLD/ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	G	ANALGESICS - OPIOID
HYDROCODONE/IBUPROFEN TAB 10-200MG	-	B	ANALGESICS - OPIOID
HYDROCORTISONE ACETATE/PRAMOXINE CREAM	-	G	ANORECTAL AND RELATED PRODUCTS
hydrocortisone butyrate cream (LOCOID equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE BUTYRATE LIPO CREAM	-	NC	DERMATOLOGICALS
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate oint (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate soln (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone cream (PROCTOCORT equiv)	-	G	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	G	ANORECTAL AGENTS
hydrocortisone lotion (HYTONE equiv)	-	G	DERMATOLOGICALS
hydrocortisone lotion (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone lotion 2% (ALA SCALP equiv)	-	NC	DERMATOLOGICALS
hydrocortisone oint	-	G	DERMATOLOGICALS
HYDROCORTISONE PAK	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	G	DERMATOLOGICALS
hydrocortisone supp (ANUSOL HC equiv)	-	G	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	G	CORTICOSTEROIDS
hydrocortisone valerate cream (WESTCORT equiv)	-	NC	DERMATOLOGICALS
hydrocortisone valerate oint (WESTCORT equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE/PRAMOXINE SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
hydromorphone ER tab (EXALGO TAB equiv)	-	NC	ANALGESICS - OPIOID
HYDROMORPHONE SUPP	-	NC	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	G	ANALGESICS - OPIOID
hydroquinone cream (LUSTRA equiv)	-	EXC	DERMATOLOGICALS
hydroquinone cream/sunscreen (LUSTRA ULTRA equiv)	-	NC	DERMATOLOGICALS
hydroquinone micro cream (EPIQUIN MICRO equiv)	-	NC	DERMATOLOGICALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	G	ANTIMALARIALS
HYDROXYM GEL	-	NC	DERMATOLOGICALS
HYDROXYPROGESTERONE CAPROATE INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyurea cap (HYDREA equiv)	-	G	ANTINEOPLASTICS
hydroxyzine pamoate cap (VISTARIL equiv)	-	G	ANTI-ANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	G	ANTI-ANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	G	ANTI-ANXIETY AGENTS
HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	DERMATOLOGICALS
HYLAMEND GEL FIRST AID	-	NC	ANTISEPTICS & DISINFECTANTS
HYLINATE LOTION	-	NC	DERMATOLOGICALS
HYMOVIS INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
HYOPHEN TAB	-	B	ANTI-INFECTIVE AGENTS - MISC.
hyopphen tab (PROSED DS equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
HYOSCYAMINE INJ	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
hyoscyamine sulfate CR tab (LEVBID equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate elixir (LEVSIN equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate soln (LEVSIN equiv)	-	G	ULCER DRUGS
hyoscyamine tab (LEVSIN equiv)	-	G	ULCER DRUGS
HYQVIA INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
HYRIMOZ INJ (adalimumab-adaz)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HYRMIOZ PFS INJ (adalimumab-adaz)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
IBRANCE CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBRANCE TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBSRELA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
IBU 600-EZS KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	-	G	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab ((RX only))	-	G	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF Infertility	LD Limited Distribution
PA	Plan Exclusion	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL Quantity Limit	RDX Restricted to Diagnosis
ST	Prior Authorization	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
	Restricted to Specialist	VAC Vaccine Program	¢ RxCENTS
	Step Therapy		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ibuprofen-famotidine tab (DUEXIS equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
icatibant inj (FIRAZYR equiv)	LMSP-PA	G	HEMATOLOGICAL AGENTS - MISC.
ICLUSIG TAB (QL= 1 tab/day; Only available through AcariaHealth 800-511-5144)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
icosapent ethyl cap (VASCEPA equiv)	-	NC	ANTIHYPERLIPIDEMICS
IDACIO INJ (adalimumab-aacf)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IHEEZO GEL	-	NC	OPHTHALMIC AGENTS
ILEVRO OPHTH SUSP	-	B	OPHTHALMIC AGENTS
imatinib tab (GLEEVEC equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 140MG (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 140MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 280MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 420MG, 560MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
imipramine pamoate cap (TOFRANIL PM equiv)	-	G	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	G	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	G	DERMATOLOGICALS
IMIQUIMOD CREAM 3.75%	-	NC	DERMATOLOGICALS
imiquimod cream 3.75% (IMIQUIMOD equiv)	-	NC	DERMATOLOGICALS
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	B	MIGRAINE PRODUCTS
IMITREX NASAL SPRAY, SUMATRIPTAN NASAL SPRAY	-	NC	MIGRAINE PRODUCTS
IMITREX TAB	-	NC	MIGRAINE PRODUCTS
IMOVAX INJ	VAC	EXC	VACCINES
IMPAVIDO CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
IMPEKLO LOTION	-	NC	DERMATOLOGICALS
IMPOYZ CREAM	-	NC	DERMATOLOGICALS
IMVEXXY SUPP	-	NC	VAGINAL PRODUCTS
INBRIJA INH POWDER (QL= 10 caps/day)	PA-QL	B	ANTIPARKINSON AND RELATED THERAPY AGENTS
INCRELEX INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
indapamide tab (LOZOL equiv)	-	G	DIURETICS
INDERAL XL CAP, INNOPRAN XL CAP	-	NC	BETA BLOCKERS
INDOCIN SUPP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INDOCIN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin cap (INDOCIN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
INDOMETHACIN CAP, TIVORBEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
indomethacin CR cap (INDOCIN SR equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
indomethacin suppository (INDOCIN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin susp (INDOCIN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INFLATHERM PAK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INGREZZA CAP (QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INGREZZA PACK 40-80MG (QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INPEFA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
INPEN INSULIN INJECTION DEVICE	-	NC	MEDICAL DEVICES AND SUPPLIES
INQOVI TAB (QL= 5 tabs/28 days)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INREBIC CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART PENFILL INJ	-	NC	ANTIDIABETICS
INSULIN GLARGINE SOLN PEN-INJ	-	B	ANTIDIABETICS
INSULIN GLARGINE-YFGN (SINGLE PEN)	-	NC	ANTIDIABETICS
INSULIN LISPRO INJ (HUMALOG equiv)	-	G	ANTIDIABETICS
INSULIN LISPRO KWIKPEN, INSULIN LISPRO JR KWIKPEN, ADMELOG SOLOSTAR INJ, HUMALOG TEMPO PEN	-	NC	ANTIDIABETICS
INSULIN LISPRO PROTAMINE PEN INJ (HUMALOG equiv)	-	NC	ANTIDIABETICS
INSULIN SYRINGE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
INTELENCE TAB	-	B	ANTIVIRALS
INTENSE COUGH LIQUID	-	NC	COUGH/COLD/ALLERGY
INTERMEZZO SL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
INTRAROSA SUPP	-	NC	VAGINAL PRODUCTS
INTRON-A INJ	MSP	B	ANTINEOPLASTICS
INVEGA HAFYERA INJ	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
INVEGA INJ	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
INVEGA TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
INVELTYS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
INVIRASE CAP	-	B	ANTIVIRALS
INVIRASE TAB	-	B	ANTIVIRALS
INVOKAMET TAB	-	NC	ANTIDIABETICS
INVOKAMET XR TAB	-	NC	ANTIDIABETICS
INVOKANA TAB	-	NC	ANTIDIABETICS
IODOFLEX PAD	-	NC	ANTISEPTICS & DISINFECTANTS
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	G	DERMATOLOGICALS
iodoquinol/hydrocortisone cream 1.9-1% (VYTONE equiv)	-	NC	DERMATOLOGICALS
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	NC	DERMATOLOGICALS
IOPIDINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
IPOL INJ	VAC	\$0	VACCINES
ipratropium nasal spray (ATROVENT equiv)	-	G	NASAL AGENTS - SYSTEMIC AND TOPICAL

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ipratropium neb soln (ATROVENT equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
irbesartan tab (AVAPRO equiv)	-	G	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	G	ANTIHYPERTENSIVES
IRESSA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ISENTRESS (HD) TAB	-	B	ANTIVIRALS
ISENTRESS CHEW TAB	-	B	ANTIVIRALS
ISENTRESS POWDER PACK	-	B	ANTIVIRALS
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	\$0	CONTRACEPTIVES
ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	B	MIGRAINE PRODUCTS
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	G	MIGRAINE PRODUCTS
isoniazid syrup (ISONIAZID equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	G	ANTIMYCOBACTERIAL AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
isosorbide dinitrate SL tab	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate tab 40mg (ISORDIL equiv)	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
isosorbide mononitrate ER tab (IMDUR equiv)	-	G	ANTIANGINAL AGENTS
ISOSORBIDE MONONITRATE TAB	-	G	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	G	ANTIANGINAL AGENTS
isotretinoin cap 25mg (ABSORICA equiv)	-	NC	DERMATOLOGICALS
isotretinoin cap 35mg (ABSORICA equiv)	-	NC	DERMATOLOGICALS
ISOXSUPRINE TAB	-	G	CARDIOVASCULAR AGENTS - MISC.
isradipine cap (DYNACIRC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
ISTURISA TAB 10MG (QL= 6 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ISTURISA TAB 1MG (QL= 8 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ISTURISA TAB 5MG (QL= 2 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
itraconazole cap (SPORANOX equiv)	-	G	ANTIFUNGALS
itraconazole soln (SPORANOX equiv)	PA	G	ANTIFUNGALS
IVERMECTIN CREAM	-	NC	DERMATOLOGICALS
ivermectin cream (SOOLANTRA equiv)	-	NC	DERMATOLOGICALS
IVERMECTIN LOTION	-	NC	DERMATOLOGICALS
ivermectin tab (STROMEKTOL equiv)	PA	G	ANTHELMINTICS
IWILFIN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IXCHIQ INJ	-	NC	VACCINES
IYUZEH OPHTH DROPS	-	NC	OPHTHALMIC AGENTS
JADENU SPRINKLE	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JANUMET TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JANUMET XR TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JANUVIA TAB (QL= 1 tab/day)	QL-¢	B	ANTIDIABETICS
JARDIANCE TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
JAYPIRCA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JENLIVA CAP	-	NC	MULTIVITAMINS
JENTADUETO TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JESDUVROQ TAB	-	NC	HEMATOPOIETIC AGENTS
jinteli tab (FEMHRT equiv)	-	G	ESTROGENS
JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
JUBLIA SOLN	-	NC	DERMATOLOGICALS
JULUCA TAB	-	B	ANTIVIRALS
JUXTAPID CAP	-	NC	ANTIHYPERTENSIVES
JYLAMVO SOLN, XATMEP SOLN (Prior Authorization required for members age 9 or older)	PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
JYNARQUE TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
KALETRA TAB	-	B	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
KAPSPARGO CAP	-	NC	BETA BLOCKERS
KAPVAY TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
KARBINAL ER SUSP	-	NC	ANTIHISTAMINES
KATERZIA SUSP (Prior Authorization required for members age 9 or older)	PA	B	CALCIUM CHANNEL BLOCKERS
KEFLEX CAP 750MG	-	NC	CEPHALOSPORINS
kelnor tab (DEMULEN equiv)	-	\$0	CONTRACEPTIVES
KENALOG INJ	-	NC	CORTICOSTEROIDS
KENALOG INJ, TRIAMCINOLONE ACE INJ	-	NC	CORTICOSTEROIDS
KERAFOAM	-	NC	DERMATOLOGICALS
KERALAC CREAM	-	NC	DERMATOLOGICALS
KERAMATRIX	-	NC	DERMATOLOGICALS
KERASTAT CREAM	-	NC	DERMATOLOGICALS
KERASTAT GEL	-	NC	DERMATOLOGICALS
KERENDIA TAB (QL= 1 tab/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
KERYDIN SOLN	-	NC	DERMATOLOGICALS
KESIMPTA INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
KETAMINE HCL TROCHES	-	NC	GENERAL ANESTHETICS
ketoconazole cream (NIZORAL CREAM equiv)	-	G	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	G	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	G	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
KETOPROFEN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketoprofen cap (ORUDIS equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KETOPROFEN ER CAP	-	B	ANALGESICS - ANTI-INFLAMMATORY
KETOROLAC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ketorolac inj (TORADOL equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
ketorolac ophth soln (ACULAR (LS) equiv)	-	G	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
KETOSTIX	OTC	G	DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv)	OTC	EXC	OPHTHALMIC AGENTS
KEVEYIS TAB	-	NC	DIURETICS
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	\$0	TOXOIDS
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	\$0	TOXOIDS
KISQALI PAK (QL= 91 tabs/28 days)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KISQALI TAB (QL= 63 tabs/28 days)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KITABIS PAK NEB SOLN	-	NC	AMINOGLYCOSIDES
KLARITY-B DROPS	-	NC	OPHTHALMIC AGENTS
KLARITY-L DROPS	-	NC	OPHTHALMIC AGENTS
KLISYRI OINT	-	NC	DERMATOLOGICALS
KLOXXADO NASAL SPRAY	-	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
KOMBIGLYZE XR TAB	-	NC	ANTIDIABETICS
KONVOMEK SUSP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS
KORLYM TAB	-	NC	ANTIDIABETICS
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
K-PHOS TAB	-	B	MINERALS & ELECTROLYTES
KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KRINTAFEL TAB	-	B	ANTIMALARIALS
KRISTALOSE PACK, LACTULOSE PACK	-	NC	LAXATIVES
KRISTALOSE PACKET	-	NC	LAXATIVES
K-TAB	-	G	MINERALS & ELECTROLYTES
KUVAN POWDER PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KUVAN TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KYBELLA INJ	-	NC	DERMATOLOGICALS
KYNAMRO INJ	-	NC	ANTIHYPERTENSIVES
KYNMOBI FILM	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYNMOBI TITRATION KIT	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYZATREX CAP, JATENZO CAP, TLANDO CAP	-	NC	ANDROGENS-ANABOLIC
L.E.T. GEL	-	NC	DERMATOLOGICALS
labetalol tab (NORMODYNE equiv)	-	G	BETA BLOCKERS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
lacosamide oral solution (VIMPAT equiv)	-	G	ANTICONVULSANTS
lacosamide tab (VIMPAT equiv)	-	G	ANTICONVULSANTS
LACRISERT OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
LACTIC ACID LOTION	-	G	DERMATOLOGICALS
lactulose soln	-	G	GASTROINTESTINAL AGENTS - MISC.
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	\$0	ANTIVIRALS
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	B	ANTIVIRALS
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	B	ANTICONVULSANTS
lamivudine soln (EPIVIR equiv)	-	G	ANTIVIRALS
lamivudine tab (EPIVIR equiv)	-	G	ANTIVIRALS
lamivudine tab 100mg (EPIVIR HBV equiv)	-	G	ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv)	-	G	ANTIVIRALS
lamotrigine chew tab (LAMICTAL equiv)	-	G	ANTICONVULSANTS
lamotrigine ER tab (LAMICTAL XR equiv)	-	G	ANTICONVULSANTS
lamotrigine ODT (LAMICTAL equiv)	-	G	ANTICONVULSANTS
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	G	ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	G	ANTICONVULSANTS
LAMPIT TAB (Restricted to Infectious Disease Specialist)	RS	B	ANTI-INFECTIVE AGENTS - MISC.
LANCET KIT	OTC	G	MEDICAL DEVICES AND SUPPLIES
LANCETS	OTC	G	MEDICAL DEVICES AND SUPPLIES
LANOXIN INJ	-	NC	CARDIOTONICS
LANOXIN TAB 62.5MCG	-	NC	CARDIOTONICS
lansoprazole cap (PREVACID equiv) (Rx Only)	-	G	ULCER DRUGS
lansoprazole odt (PREVACID SOLUTAB equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
LANSOPRAZOLE SUSP	PA	B	ULCER DRUGS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
LANSOPRAZOLE/AMOXICILLIN/CLARITHROMYCIN KIT	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
lanthanum carbonate chew tab (FOSRENOL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
LANTUS INJ, INSULIN GLARGINE INJ	-	NC	ANTIDIABETICS
lapatinib ditosylate tab (TYKERB equiv)	LMSP-PA	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LASTACFT OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	G	OPHTHALMIC AGENTS
LATISSE SOLN	-	NC	DERMATOLOGICALS
LATUDA TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0	CONTRACEPTIVES
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days)	PA-QL	B	ANALGESICS - OPIOID
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANTIVIRALS
leflunomide tab (ARAVA equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	G	MISCELLANEOUS THERAPEUTIC CLASSE
LENVIMA CAP (QL= 3 caps/day; Only available through Optum 877-445-6874)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LESCOL CAP	-	NC	ANTHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
LESCOL XL TAB	-	NC	ANTHYPERLIPIDEMICS
letrozole tab (FEMARA equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	G	ANTINEOPLASTICS
LEUKERAN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKINE INJ	-	NC	HEMATOPOIETIC AGENTS
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA)	QL-ST	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levalbuterol neb soln (XOPENEX equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVEMIR FLEXTOUCH INJ	-	B	ANTIDIABETICS
LEVEMIR INJ	-	B	ANTIDIABETICS
levetiracetam ER tab (KEPPRA XR equiv)	-	G	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	G	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	G	ANTICONVULSANTS
LEVITRA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
LEVOBUNOLOL OPHTH SOLN	-	G	OPHTHALMIC AGENTS
levobunolol ophth soln (BETAGAN equiv)	-	G	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocarnitine tab (CARNITOR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocetirizine soln (XYZAL equiv)	-	EXC	ANTIHISTAMINES
levocetirizine tab (XYZAL equiv)	-	EXC	ANTIHISTAMINES
levofloxacin ophth soln (QUIXIN equiv)	-	G	OPHTHALMIC AGENTS
LEVOFLOXACIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
LEVOFLOXACIN OPHTH SOLN 0.5%	-	G	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	G	FLUOROQUINOLONES
LEVOFLOXACIN SOLN 25MG/ML	-	G	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	G	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	\$0	CONTRACEPTIVES
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	NC	CONTRACEPTIVES
LEVORPHANOL TAB	-	NC	ANALGESICS - OPIOID
levorphanol tab (LEVORPHANOL equiv)	-	NC	ANALGESICS - OPIOID
LEVOTHYROXINE INJ	-	NC	THYROID AGENTS
LEVOTHYROXINE INJ 100MCG/ML	-	NC	THYROID AGENTS
levothyroxine tab (SYNTHROID equiv)	-	G	THYROID AGENTS
LEXIVA SUSP	-	B	ANTIVIRALS
LIALDA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
LICART PATCH	-	NC	DERMATOLOGICALS
LIDO/MENTHOL SPRAY	-	NC	DERMATOLOGICALS
LIDO/RAC/TET GEL	-	NC	DERMATOLOGICALS
LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
lidocaine cream 3% (LIDAMANTLE equiv)	-	G	DERMATOLOGICALS
lidocaine cream 3.88% (LIDOTRAL CREAM equiv)	-	NC	DERMATOLOGICALS
LIDOCAINE GEL	-	B	DERMATOLOGICALS
lidocaine gel (GLYDO equiv)	-	G	DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	G	DERMATOLOGICALS
lidocaine lotion	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
lidocaine oint (QL= 36gm/fill)	QL	G	DERMATOLOGICALS
lidocaine oint/transparent dressing kit	-	NC	DERMATOLOGICALS
LIDOCAINE ORAL SOLN 4%	-	NC	MOUTH/THROAT/DENTAL AGENTS
lidocaine patch 3.5% (GEN7T equiv)	-	NC	DERMATOLOGICALS
lidocaine patch 4% (LIDODERM equiv)	-	NC	DERMATOLOGICALS
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	QL	G	DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	G	DERMATOLOGICALS
LIDOCAINE SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	G	ANORECTAL AGENTS
LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT	-	NC	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	G	DERMATOLOGICALS
LIDOCIN GEL	-	NC	DERMATOLOGICALS
LIDODERM PATCH 4%	-	NC	DERMATOLOGICALS
LIDOLOG KIT	-	NC	CORTICOSTEROIDS
LIDOSTREAM KIT	-	NC	DERMATOLOGICALS
LIDOTIN PAK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LIDOTRAL CREAM (lidocaine cream equiv)	-	NC	DERMATOLOGICALS
LIDOTREX GEL	-	NC	DERMATOLOGICALS
LIDOVEX CREAM	-	NC	DERMATOLOGICALS
LIKMEZ SUSP (Prior Authorization required for members age 9 or older)	PA	B	ANTI-INFECTIVE AGENTS - MISC.
LINDANE SHAMPOO	-	G	DERMATOLOGICALS
linezolid susp (Restricted to Infectious Disease Specialist)	RS	G	ANTI-INFECTIVE AGENTS - MISC.
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	G	ANTI-INFECTIVE AGENTS - MISC.
LINZESS CAP (QL= 1 cap/day)	PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	G	THYROID AGENTS
LIPITOR TAB	-	NC	ANTIHYPERLIPIDEMICS
LIQREV SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
lisdexamfetamine dimesylate cap (VYVANSE equiv) (QL= 1 cap/day)	QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
lisdexamfetamine dimesylate chew tab (VYVANSE equiv) (QL= 1 tab/day; Members age 9 or older require Prior Authorization)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	G	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	G	ANTIHYPERTENSIVES
LITFULO CAP	-	NC	DERMATOLOGICALS
lithium carbonate cap (ESKALITH ER equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate tab	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LITHOSTAT TAB	-	B	GENITOURINARY AGENTS - MISCELLANEOUS
LIVALO TAB	-	NC	ANTIHYPERLIPIDEMICS
LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTIVIRALS
L-METHYLFOLATE TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LO LOESTRIN TAB	-	NC	CONTRACEPTIVES
LOCOID CREAM	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
LOCOID LIPOCREAM	-	NC	DERMATOLOGICALS
LOCOID OINT	-	NC	DERMATOLOGICALS
LOCOID SOLN	-	NC	DERMATOLOGICALS
LODOCO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
loestrin 21 tab	-	NC	CONTRACEPTIVES
loestrin tab	-	NC	CONTRACEPTIVES
LOKELMA PAK	PA	B	MISCELLANEOUS THERAPEUTIC CLASSES
LOMAIRA TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
LONHALA MAGNAIR SOLN	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LONSURF TAB	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
loperamide cap (IMODIUM equiv)	-	NC	ANTIARRHEALS
loperamide hcl soln (LOPERAMIDE equiv)	OTC	NC	ANTIARRHEAL/PROBIOTIC AGENTS
lopinavir/ritonavir soln (KALETRA equiv)	-	G	ANTIVIRALS
lopinavir/ritonavir tab (KALETRA equiv)	-	G	ANTIVIRALS
loratadine cap (CLARITIN equiv)	OTC	EXC	ANTIHISTAMINES
lorazepam conc (ATIVAN equiv)	-	G	ANTIANSIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	G	ANTIANSIETY AGENTS
LORBRENA TAB 25MG (QL= 1 tab/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LOREEV XR CAP	-	NC	ANTIANSIETY AGENTS
LORTAB ELIXIR	-	B	ANALGESICS - OPIOID
LORVATUS PHARMAPAK KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
losartan tab (COZAAR equiv)	-	G	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	G	ANTIHYPERTENSIVES
LOTEMAX OPHTH GEL	-	B	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	B	OPHTHALMIC AGENTS
LOTEMAX SM GEL 0.38%	-	NC	OPHTHALMIC AGENTS
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	G	OPHTHALMIC AGENTS
loteprednol ophth susp (LOTEMAX equiv)	-	G	OPHTHALMIC AGENTS
LOTRIMIN AF CREAM	-	NC	DERMATOLOGICALS
LOTRISONE CREAM	-	NC	DERMATOLOGICALS
lovastatin tab (MEVACOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
loxapine cap (LOXITANE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	PA-QL	G	GASTROINTESTINAL AGENTS - MISC.
LUCEMYRA TAB (QL= 96 tabs/7 days)	PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUCENTIS INJ	MSP-PA	B	OPHTHALMIC AGENTS
LULICONAZOLE CREAM, LUZU CREAM	-	NC	DERMATOLOGICALS
LUMAKRAS TAB (QL= 8 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMAKRAS TAB 320MG (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMIGAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
LUMIZYME/MYOZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
LUMRYZ PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
LUPRON DEPOT PED INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT-PED INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
lurasidone hcl tab (LATUDA equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LUVIRA CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LUXIQ FOAM	-	NC	DERMATOLOGICALS
LYBALVI TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LYNPARZA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYRICA CAP	-	NC	ANTICONVULSANTS
LYRICA CAP 225MG	-	NC	ANTICONVULSANTS
LYRICA CAP 300MG	-	NC	ANTICONVULSANTS
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYUMJEV INJ	-	B	ANTIDIABETICS
LYUMJEV KWIKPEN INJ	-	B	ANTIDIABETICS
LYUMJEV TEMPO PEN INJ	-	NC	ANTIDIABETICS
LYVISPAH GRANULE PACKET (Members age 9 or older require Prior Authorization)	PA	B	MUSCULOSKELETAL THERAPY AGENTS
MACRILEN PACK	-	NC	DIAGNOSTIC PRODUCTS
MACUGEN INJ	MSP-PA	B	OPHTHALMIC AGENTS
MALARONE TAB	-	NC	ANTIMALARIALS
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	G	DERMATOLOGICALS
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$0	MEDICAL DEVICES AND SUPPLIES
MAPROTILINE TAB	-	G	ANTIDEPRESSANTS
maraviroc tab (SELZENTRY equiv)	-	G	ANTIVIRALS
MARPLAN TAB	-	B	ANTIDEPRESSANTS
MATULANE CAP	-	B	ANTINEOPLASTICS
MAVENCLAD THERAPY PAK (Only available through Walgreens 888-347-3416)	LD	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAVYRET PAK (QL= 5 packs/day)	LMSP-PA-QL	B	ANTIVIRALS
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	B	ANTIVIRALS
MAXALT MLT TAB	-	NC	MIGRAINE PRODUCTS
MAXALT TAB	-	NC	MIGRAINE PRODUCTS
MAXIDEX OPHTH SOLN	-	B	OPHTHALMIC AGENTS
MAYZENT TAB	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAYZENT TAB STARTER PACK	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
meclizine chew tab (BONINE equiv) (Rx Only)	-	G	ANTIEMETICS
meclizine tab (ANTIVERT equiv) (Rx Only)	-	G	ANTIEMETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
MECLOFENAMATE CAP (Step Therapy requires trial of two: diclofenac potassium tab, ketoprofen cap, ibuprofen, or naproxen)	ST	G	ANALGESICS - ANTI-INFLAMMATORY
MEDI-PATCH W/LIDOCAINE PATCH	-	NC	DERMATOLOGICALS
MEDROL TAB	-	NC	CORTICOSTEROIDS
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	G	PROGESTINS
mefenamic acid cap (PONSTEL equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
mefloquine tab (LARIAM equiv)	-	G	ANTIMALARIALS
megestrol ES susp (MEGACE ES equiv)	-	G	PROGESTINS
megestrol susp (MEGACE equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST SOLN	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 2MG (QL= 1 tab/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKTOVI TAB (QL= 6 tabs/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam cap (VIVLODEX equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MELOXICAM COMFORT KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MELOXICAM SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
meloxicam tab (MOBIC equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
MELPHALAN TAB	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MELQUIN 3 SOLN	-	NC	DERMATOLOGICALS
memantine ER cap (NAMENDA XR equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine soln (NAMENDA equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine tab (NAMENDA equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MENACTRA INJ	VAC	\$0	VACCINES
MENEST TAB	-	B	ESTROGENS
MENOSTAR PATCH	-	NC	ESTROGENS
MENQUADFI INJ	VAC	\$0	VACCINES
MENTAX CREAM	-	NC	DERMATOLOGICALS
MENTHOREAL 10 THERAPY PACK	-	NC	DERMATOLOGICALS
MENVEO INJ	VAC	\$0	VACCINES
meperidine tab (DEMEROL equiv)	-	NC	ANALGESICS - OPIOID
meprobamate tab (MILTOWN equiv)	-	NC	ANTI-ANXIETY AGENTS
mercaptapurine tab (PURINETHOL equiv)	-	G	ANTINEOPLASTICS
mesalamine DR cap (DELZICOL equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesalamine DR tab (LIALDA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema kit (ROWASA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (APRISO equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (PENTASA CR equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesalamine supp (CANASA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
mesalamine tab (ASACOL equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
MESALAMINE TAB DR	-	NC	GASTROINTESTINAL AGENTS - MISC.
MESNEX TAB	LMSP	B	ANTINEOPLASTICS
METANX CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
METAPROTERENOL SYRUP	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
METAPROTERENOL TAB	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
metaxalone tab (SKELAXIN equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
METAXALONE TAB 400MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
METDRAY GEL	-	NC	DERMATOLOGICALS
metformin ER osmotic tab (FORTAMET equiv)	-	NC	ANTIDIABETICS
metformin ER osmotic tab (GLUMETZA equiv)	-	NC	ANTIDIABETICS
metformin ER tab (GLUCOPHAGE XR equiv)	-	G	ANTIDIABETICS
metformin soln (RIOMET equiv)	-	G	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	G	ANTIDIABETICS
METFORMIN TAB	-	NC	ANTIDIABETICS
methadone soln	-	G	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv)	-	G	ANALGESICS - OPIOID
methadose tab	-	G	ANALGESICS - OPIOID
methamphetamine tab (DESOXYN equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methazolamide tab (NEPTAZANE equiv)	-	G	DIURETICS
methenamine hippurate tab (HIPREX equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
methenamine mandelate tab	-	G	ANTI-INFECTIVE AGENTS - MISC.
methimazole tab (TAPAZOLE equiv)	-	G	THYROID AGENTS
METHITEST TAB (Step Therapy requires trial of ANDROGEL or ANDRODERM)	ST	B	ANDROGENS-ANABOLIC
methocarbamol tab (ROBAXIN equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
METHOCARBAMOL TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
METHOTREXATE INJ	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	G	ANTINEOPLASTICS
METHOXSALEN CAP	-	B	DERMATOLOGICALS
methoxsalen cap (OXSORALEN ULTRA equiv)	-	G	DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	G	ULCER DRUGS
methsuximide cap (CELONTIN equiv)	-	G	ANTICONVULSANTS
METHYLDOPA TAB	-	G	ANTIHYPERTENSIVES
methylidopa tab (ALDOMET equiv)	-	G	ANTIHYPERTENSIVES
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB	-	G	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	G	OXYTOCICS
methylphenidate CD cap (METADATE CD equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate chew tab (METHYLIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate ER cap (RITALIN LA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate ER cap (APTENSIO XR equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
METHYLPHENIDATE ER TAB	-	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
methylphenidate ER tab	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate tab (RITALIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylphenidate td patch (DAYTRANA equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	G	CORTICOSTEROIDS
methylprednisolone dose pack (MEDROL equiv)	-	G	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	G	CORTICOSTEROIDS
methylprenisolone sod succinate inj (SOLU-MEDROL equiv)	-	G	CORTICOSTEROIDS
methyltestosterone cap	-	NC	ANDROGENS-ANABOLIC
METIPRANOLOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
metoclopramide soln (REGLAN equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	G	DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	G	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	G	BETA BLOCKERS
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	G	ANTIHYPERTENSIVES
METZOZLV ODT	-	NC	GASTROINTESTINAL AGENTS - MISC.
metronidazole cap (FLAGYL equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	G	DERMATOLOGICALS
metronidazole gel 0.75% (METROGEL equiv)	-	G	DERMATOLOGICALS
metronidazole gel 1% (METROGEL equiv) (Step Therapy requires trial of metronidazole gel 0.75%)	ST	G	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	G	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
metronidazole vaginal gel (METROGEL equiv)	-	G	VAGINAL PRODUCTS
metyrosine cap (DEMSEER equiv)	-	NC	ANTIHYPERTENSIVES
mexiletine hcl cap	-	G	ANTIARRHYTHMICS
MEXPAROX HC CREAM	-	NC	DERMATOLOGICALS
MICARDIS HCT TAB	-	NC	ANTIHYPERTENSIVES
MICLARA LIQUID	-	NC	ANTIHISTAMINES
MICORT-HC CREAM	-	NC	DERMATOLOGICALS
MICROVIX LP PAK	-	NC	DERMATOLOGICALS
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
midodrine tab (PROAMATINE equiv)	-	G	VASOPRESSORS
MIEBO OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
mifepristone tab (KORLYM equiv) (QL= 4 tabs/day; Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA-QL	B	ANTIDIABETICS
mifepristone tab (MIFIPREX equiv)	LD-PA-QL	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
MIGERGOT SUPP	-	NC	MIGRAINE PRODUCTS
MIGLITOL TAB	-	B	ANTIDIABETICS
miglitol tab (MIGLITOL equiv)	-	G	ANTIDIABETICS
miglustat cap (ZAVESCA equiv) (Only available through Accredo 800-803-2523)	LD-PA	G	HEMATOPOIETIC AGENTS
MILLIPRED DP PAK	-	NC	CORTICOSTEROIDS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
MILLIPRED TAB	-	NC	CORTICOSTEROIDS
minocycline cap (MINOCIN equiv)	-	G	TETRACYCLINES
MINOCYCLINE ER CAP	-	NC	TETRACYCLINES
minocycline ER tab (SOLODYN equiv)	-	NC	TETRACYCLINES
minocycline tab (DYNACIN equiv) (Step therapy requires trial of minocycline caps)	ST	G	TETRACYCLINES
MINOLIRA TAB	-	NC	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	G	ANTIHYPERTENSIVES
MIRALAX PACKET	OTC	EXC	LAXATIVES
MIRAPEX ER TAB	-	NC	ANTIPARKINSON AGENTS
MIRCERA INJ	-	NC	HEMATOPOIETIC AGENTS
MIRENA IUD	-	\$0	CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	G	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	G	ANTIDEPRESSANTS
MIRVASO GEL	-	EXC	DERMATOLOGICALS
misoprostol tab (CYTOTEC equiv)	-	G	ULCER DRUGS
M-M-R II INJ	VAC	\$0	VACCINES
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MODERIBA TAB	-	NC	ANTIVIRALS
moexipril tab (UNIVASC equiv)	-	G	ANTIHYPERTENSIVES
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	G	ANTIHYPERTENSIVES
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	G	ANTIHYPERTENSIVES
MOLINDONE TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
mometasone cream (ELOCON equiv)	-	G	DERMATOLOGICALS
mometasone nasal spray (NASONEX equiv)	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
mometasone oint (ELOCON equiv)	-	G	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	G	DERMATOLOGICALS
MONOCLATE-P INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
MONODOX CAP 75MG	-	NC	TETRACYCLINES
montelukast chew tab (SINGULAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast granule pack (SINGULAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
MONUROL GRANULE PACK	-	B	ANTI-INFECTIVE AGENTS - MISC.
MORPHABOND TAB	-	NC	ANALGESICS - OPIOID
MORPHINE SULF SOLN 10MG/5ML	-	G	ANALGESICS - OPIOID
MORPHINE SULFATE ER BEAD CAP	-	NC	ANALGESICS - OPIOID
MORPHINE SULFATE ER CAP	-	NC	ANALGESICS - OPIOID
morphine sulfate ER cap (KADIAN equiv)	-	NC	ANALGESICS - OPIOID
morphine sulfate ER tab (MS CONTIN equiv)	-	G	ANALGESICS - OPIOID
morphine sulfate soln	-	G	ANALGESICS - OPIOID
MORPHINE SULFATE SUPP	-	G	ANALGESICS - OPIOID
MORPHINE SULFATE TAB	-	G	ANALGESICS - OPIOID
MOTEGRITY TAB (QL= 1 tab/day)	PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
MOTPOLY XR CAP	-	NC	ANTICONSULSANTS
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
MOVANTIK TAB	PA	B	GASTROINTESTINAL AGENTS - MISC.
MOVIPREP SOLN (Step Therapy requires trial of CLENPIQ)	ST	B	LAXATIVES
MOXATAG TAB	-	NC	PENICILLINS
MOXATAG TAB 775MG	-	NC	PENICILLINS
MOXEZA OPHTH SOLN 0.5%	-	NC	OPHTHALMIC AGENTS
MOXEZA OPHTH SOLN, MOXIFLOXACIN OPHTH SOLN, VIGAMOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	G	OPHTHALMIC AGENTS
MOXIFLOXACIN SOLN	-	NC	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	G	FLUOROQUINOLONES
MOZOBIL INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
MPM PAK	-	NC	OXYTOCICS
MUCINEX LIQUID	-	NC	COUGH/COLD/ALLERGY
MUCINEX TAB	-	NC	COUGH/COLD/ALLERGY
MULPLETA TAB	-	NC	HEMATOPOIETIC AGENTS
MULTAQ TAB	-	B	ANTIARRHYTHMICS
MULTIGEN FOLIC TAB	-	G	HEMATOPOIETIC AGENTS
MULTIGEN PLUS TAB	-	G	HEMATOPOIETIC AGENTS
MULTIGEN TAB	-	G	HEMATOPOIETIC AGENTS
MULTI-MAC TAB	-	NC	MULTIVITAMINS
MULTIVITAMIN/FLOURIDE CHEW 0.25MG	-	G	MULTIVITAMINS
MULTIVITAMIN/FLOURIDE CHEW 1MG	-	G	MULTIVITAMINS
MULTIVITAMIN/FLUORIDE CHEW TAB	-	G	MULTIVITAMINS
multivitamin/minerals tab (STROVITE equiv)	-	G	MULTIVITAMINS
mupirocin cream (BACTROBAN CREAM equiv)	-	NC	DERMATOLOGICALS
mupirocin oint (BACTROBAN OINT equiv)	-	G	DERMATOLOGICALS
MUSE SUPP (QL= 6 supp/30 days; Step therapy requires trial of sildenafil)	QL-ST	B	CARDIOVASCULAR AGENTS - MISC.
MYALEPT INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
MYCAPSSA CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
mycophenolate DR tab (MYFORTIC equiv)	-	G	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	G	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	G	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	G	ASSORTED CLASSES
MYDAYIS CAP 12.5MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MYDAYIS CAP 25MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MYDAYIS CAP 37.5MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MYDAYIS CAP 50MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	B	ESTROGENS
MYLERAN TAB	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MYNATAL-Z TAB	-	NC	MULTIVITAMINS
MYRBETRIQ SUSP	-	NC	URINARY ANTISPASMODICS
MYRBETRIQ TAB	-	NC	URINARY ANTISPASMODICS
MYTESI TAB	-	NC	ANTIIDIARRHEALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
nabumetone tab (RELAFEN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	G	BETA BLOCKERS
NAFLON CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAFTIFINE CREAM	-	NC	DERMATOLOGICALS
naftifine cream (NAFTIN equiv)	-	NC	DERMATOLOGICALS
naftifine gel (NAFTIN equiv)	-	NC	DERMATOLOGICALS
naftifine hcl gel 2% (NAFTIN equiv)	-	NC	DERMATOLOGICALS
NAFTIN CREAM	-	NC	DERMATOLOGICALS
NAFTIN GEL	-	NC	DERMATOLOGICALS
NAFTIN GEL 2%	-	NC	DERMATOLOGICALS
NAGLAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
naloxone hcl nasal spray (NARCAN equiv)	OTC	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone inj	-	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone prefilled inj	QL--	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	G	ANTIDOTES
NAMENDA XR CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMENDA XR TITRATION PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAPRELAN CR TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN EC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN EC TAB 500MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
naproxen EC tab (NAPROSYN EC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen EC tab 500mg (NAPROSYN EC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen susp (NAPROSYN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY	OTC	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
NARDIL TAB 15MG	-	B	ANTIDEPRESSANTS
NASCOBAL SPRAY	-	NC	HEMATOPOIETIC AGENTS
NATACHEW	-	NC	MULTIVITAMINS
NATACYN OPTH SUSP (QL= 15ml/fill)	QL	B	OPHTHALMIC AGENTS
NATAZIA TAB	-	NC	CONTRACEPTIVES
nateglinide tab (STARLIX equiv)	-	G	ANTIDIABETICS
NATESTO GEL	-	NC	ANDROGENS-ANABOLIC
NATESTO NASAL GEL	-	NC	ANDROGENS-ANABOLIC
NATPARA INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
NATROBA SUSP (QL= 1 bottle/fill)	QL	B	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
NAYZILAM SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B	ANTICONVULSANTS
neбиволол hcl tab (BYSTOLIC equiv)	¢	G	BETA BLOCKERS
NEBUSAL NEB SOLN	-	B	COUGH/COLD/ALLERGY
NEEVO DHA	-	NC	MULTIVITAMINS
NEFAZODONE TAB	-	G	ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	G	ANTIDEPRESSANTS
NENDRUX GEL	-	NC	DERMATOLOGICALS
neomycin tab	-	G	AMINOGLYCOSIDES
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	G	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	G	OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	G	OTIC AGENTS
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	G	OPHTHALMIC AGENTS
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	G	OPHTHALMIC AGENTS
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
NEONATAL 19 TAB	-	B	MULTIVITAMINS
NEONATAL FE TAB	-	B	MULTIVITAMINS
NEOSALUS FOAM	-	NC	DERMATOLOGICALS
NEOSALUS LOTION	-	NC	DERMATOLOGICALS
NEO-SYNALAR CREAM	-	NC	DERMATOLOGICALS
NEPHRON FA TAB	-	B	HEMATOPOIETIC AGENTS
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NESTABS ABC	-	NC	MULTIVITAMINS
NESTABS DHA	-	NC	MULTIVITAMINS
NESTABS ONE	-	NC	MULTIVITAMINS
NEULASTA INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPOGEN INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPRO PATCH	PA	B	ANTIPARKINSON AGENTS
NEURONTIN SOLN	-	NC	ANTICONVULSANTS
NEURONTIN TAB 600MG	-	NC	ANTICONVULSANTS
NEURONTIN TAB 800MG	-	NC	ANTICONVULSANTS
NEVANAC OPHTH SUSP	-	B	OPHTHALMIC AGENTS
NEVIRAPINE ER TAB (Step Therapy requires trial of nevirapine)	ST	G	ANTIVIRALS
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	G	ANTIVIRALS
NEVIRAPINE SUSP	-	G	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	G	ANTIVIRALS
NEXA PLUS	-	NC	MULTIVITAMINS
NEXICLON XR TAB	-	NC	ANTIHYPERTENSIVES
NEXIUM 24HR TAB	OTC	EXC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
NEXIUM GRANULE PACK	-	NC	ULCER DRUGS
NEXLETOL TAB (QL= 1 tab/day)	PA-QL	B	ANTIHYPERLIPIDEMICS
NEXLIZET TAB	-	NC	ANTIHYPERLIPIDEMICS
NEXPLANON IMPLANT	-	\$0	CONTRACEPTIVES
NEXTSTELLIS TAB	-	NC	CONTRACEPTIVES
NGENLA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
niacin cap	OTC	EXC	VITAMINS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF Infertility	LD Limited Distribution
PA	Plan Exclusion	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL Quantity Limit	RDX Restricted to Diagnosis
ST	Prior Authorization	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
	Restricted to Specialist	VAC Vaccine Program	¢ RxCENTS
	Step Therapy		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
niacin CR tab (SLO-NIACIN equiv)	OTC	EXC	VITAMINS
niacin ER tab (NIASPAN equiv)	-	G	ANTIHYPERLIPIDEMICS
niacin tab	OTC	EXC	VITAMINS
NIACIN TR TAB	OTC	EXC	VITAMINS
niacinamide tab	OTC	EXC	VITAMINS
NIACOR TAB	-	NC	ANTIHYPERLIPIDEMICS
NIASPAN ER TAB	-	NC	ANTIHYPERLIPIDEMICS
nicardipine cap (CARDENE equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTINE KIT	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	G	CALCIUM CHANNEL BLOCKERS
nifedipine ER tab (ADALAT CC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
nilutamide tab (NILANDRON equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	G	CALCIUM CHANNEL BLOCKERS
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nisoldipine ER tab (SULAR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
NISOLDIPINE ER TAB 20MG, 30MG, 40MG	-	G	CALCIUM CHANNEL BLOCKERS
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	G	ANTI-INFECTIVE AGENTS - MISC.
nitisinone cap (ORFADIN equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NITRO-BID OINT	-	B	ANTIANGINAL AGENTS
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	NC	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin monohydrate cap (MACROBID equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin susp (FURADANTIN equiv) (Covered for members age 9 or younger)	-	G	ANTI-INFECTIVE AGENTS - MISC.
NITROFURANTOIN SUSP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
NITROGLYCERIN ER CAP	-	G	ANTIANGINAL AGENTS
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	G	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	G	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	G	ANTIANGINAL AGENTS
NITROMIST SPRAY	-	B	ANTIANGINAL AGENTS
NITYR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NIVESTYM INJ	LMSP	B	HEMATOPOIETIC AGENTS
NIZATIDINE CAP	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF Infertility	LD Limited Distribution
PA	Plan Exclusion	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL Quantity Limit	RDX Restricted to Diagnosis
ST	Prior Authorization	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
	Restricted to Specialist	VAC Vaccine Program	¢ RxCENTS
	Step Therapy		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
nizatidine cap (AXID equiv)	-	G	ULCER DRUGS
NIZATIDINE SOLN (Members age 9 or older require Prior Authorization)	PA	B	ULCER DRUGS
NIZORAL A-D SHAMPOO	OTC	EXC	DERMATOLOGICALS
nizoral a-d shampoo (NIZORAL equiv)	OTC	EXC	DERMATOLOGICALS
NOCDURNA SL TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NOCTIVA EMULSION SPRAY	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NORDITROPIN INJ, NUTROPIN AQ INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	NC	CONTRACEPTIVES
norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv)	-	NC	CONTRACEPTIVES
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (NORA-QD equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	G	PROGESTINS
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	\$0	CONTRACEPTIVES
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	NC	CONTRACEPTIVES
NORGESIC TAB FORTE	-	NC	MUSCULOSKELETAL THERAPY AGENTS
NORITATE CREAM	-	NC	DERMATOLOGICALS
NORLIQVA ORAL SOLN (Members age 9 or older require Prior Authorization)	PA	B	CALCIUM CHANNEL BLOCKERS
NORPACE CR CAP	-	B	ANTIARRHYTHMICS
NORTHERA CAP	-	NC	VASOPRESSORS
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	\$0	CONTRACEPTIVES
nortrel tab (OVCON 35 equiv)	-	\$0	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	G	ANTIDEPRESSANTS
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	G	ANTIDEPRESSANTS
NORVIR CAP	-	B	ANTIVIRALS
NORVIR POWDER PACK	-	B	ANTIVIRALS
NORVIR SOLN	-	B	ANTIVIRALS
NOVACORT GEL	-	NC	DERMATOLOGICALS
NOVOFINE PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
NOVOLIN 70/30 FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 FLEXPEN RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N INJ	OTC	NC	ANTIDIABETICS
NOVOLIN R FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN R INJ	OTC	NC	ANTIDIABETICS
NOVOLIN R RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	NC	ANTIDIABETICS
NOVOLOG INJ	-	NC	ANTIDIABETICS
NOVOLOG MIX FLEXPEN INJ	-	NC	ANTIDIABETICS
NOVOLOG MIX INJ	-	NC	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	NC	ANTIDIABETICS
NOVOPEN ECHO	-	B	MEDICAL DEVICES AND SUPPLIES
NOVOSEVEN INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
NOVOTWIST PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
NOXAFIL PAK	-	B	ANTIFUNGALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
NOXAFIL TAB	-	NC	ANTIFUNGALS
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	G	THYROID AGENTS
NPLATE INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
NUBEQA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
NUCARACLINPA KIT	-	NC	DERMATOLOGICALS
NUCARARXPAK KIT	-	NC	DERMATOLOGICALS
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	B	ANALGESICS - OPIOID
NUCYNTA TAB	-	B	ANALGESICS - OPIOID
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nulido pad (NULIDO equiv)	-	NC	DERMATOLOGICALS
NULYTELY SOLN (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0	LAXATIVES
NUPLAZID CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
NUPLAZID TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
NUQUIN HP CREAM	-	NC	DERMATOLOGICALS
NURTEC ODT	-	NC	MIGRAINE PRODUCTS
NUVAKAAN II KIT	-	NC	DERMATOLOGICALS
NUVARING	-	\$0	CONTRACEPTIVES
NUVIGIL TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
NUZYRA TAB	-	NC	TETRACYCLINES
NYMALIZE SOLN	-	NC	CALCIUM CHANNEL BLOCKERS
nystatin cream (MYCOSTATIN CREAM equiv)	-	G	DERMATOLOGICALS
nystatin oint	-	G	DERMATOLOGICALS
nystatin powder	-	G	ANTIFUNGALS
nystatin susp	-	G	MOUTH/THROAT/DENTAL AGENTS
nystatin tab	-	G	ANTIFUNGALS
nystatin topical powder	-	G	DERMATOLOGICALS
nystatin/triamcinolone cream	-	NC	DERMATOLOGICALS
nystatin/triamcinolone oint	-	NC	DERMATOLOGICALS
NYVEPRIA INJ	LMSP	B	HEMATOPOIETIC AGENTS
OB COMPLETE ONE	-	NC	MULTIVITAMINS
OB COMPLETE PETITE	-	NC	MULTIVITAMINS
OB COMPLETE PREMIER	-	NC	MULTIVITAMINS
OCALIVA TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL-SF-φ	B	GASTROINTESTINAL AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	LMSP	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
OCTREOTIDE INJ 100MCG	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ODACTRA SL TAB	-	NC	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
ODEFSEY TAB	-	B	ANTIVIRALS
ODOMZO CAP	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OFEV CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	φ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ofloxacin ophth soln (OCUFLOX equiv)	-	G	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	G	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	G	FLUOROQUINOLONES
OGSIVEO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OJJAARA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
olanzapine ODT (ZYPREXA equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine tab (ZYPREXA equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
OLLIZAC POWDER	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
olmesartan tab (BENICAR equiv)	-	G	ANTIHYPERTENSIVES
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv)	-	NC	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	G	ANTIHYPERTENSIVES
olopatadine nasal spray (PATANASE equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
olopatadine ophth soln 0.1% (PATANOL equiv)	-	G	OPHTHALMIC AGENTS
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%)	QL-ST	G	OPHTHALMIC AGENTS
OLPRUVA PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
OLUX E FOAM	-	NC	DERMATOLOGICALS
OLUX FOAM	-	NC	DERMATOLOGICALS
OLYSIO CAP	-	NC	ANTIVIRALS
OMEGA-3 RX PAK COMPLETE	-	NC	ANTIHYPERLIPIDEMICS
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	G	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	G	ULCER DRUGS
omeprazole magnesium DR tab 20mg (PRILOSEC equiv)	OTC	EXC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
omeprazole tab	OTC	EXC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC	ULCER DRUGS
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC	ULCER DRUGS
OMNARIS NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
OMNIPAQUE SOLN	-	NC	DIAGNOSTIC PRODUCTS
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 G7 MIS PODS (QL= 10 pods/30 days)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 INTRO KIT (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PDM KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD GO KIT (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNITROPE INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
OMVOH INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ondansetron ODT (ZOFTRAN equiv)	-	G	ANTIEMETICS
ondansetron soln (ZOFTRAN equiv)	-	G	ANTIEMETICS
ONDANSETRON TAB	-	G	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	G	ANTIEMETICS
ONETOUCH DELICA LANCETS	OTC	G	MEDICAL DEVICES AND SUPPLIES
ONETOUCH DELICA PLUS LANCETS	OTC	G	MEDICAL DEVICES AND SUPPLIES
ONETOUCH DELICA ULTRASOFT LANCETS	OTC	G	MEDICAL DEVICES AND SUPPLIES
ONETOUCH KIT	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
ONETOUCH VERIO FLEX METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO REFLECT METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH VERIO TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
ONEXTON GEL 1.2-3.75%	-	NC	DERMATOLOGICALS
ONFI SUSP	-	NC	ANTICONVULSANTS
ONFI TAB	-	NC	ANTICONVULSANTS
ONGENTYS CAP (QL= 1 tab/day, 30 tabs per fill)	PA-QL	B	ANTIPARKINSON AND RELATED THERAPY AGENTS
ONGLYZA TAB	-	NC	ANTIDIABETICS
ONUREG TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ONYCHO-MED KIT	-	NC	DERMATOLOGICALS
ONZETRA XSAIL	-	NC	MIGRAINE PRODUCTS
OPANA ER TAB (CRUSH RESISTANT)	-	NC	ANALGESICS - OPIOID
OPANA TAB	-	NC	ANALGESICS - OPIOID
OPFOLDA CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
opium tincture	-	G	ANTIIDIARRHEALS
OPSUMIT TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
OPVEE NASAL SPRAY	-	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
OPZELURA CREAM (QL= 4 tubes/30 days for the first two months; then QL= 12 tubes/year thereafter)	PA-QL	B	DERMATOLOGICALS
ORACIT SOLN	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
ORALAIR SL TAB	-	NC	BIOLOGICALS MISC
ORAPRED ODT TAB	-	NC	CORTICOSTEROIDS
ORAVIG TAB	-	B	MOUTH/THROAT/DENTAL AGENTS
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENITRAM TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ORENITRAM TAB MONTH PAK	-	NC	CARDIOVASCULAR AGENTS - MISC.
ORFADIN CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORFADIN SUSP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ORGOVYX TAB (QL= 30 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	B	ESTROGENS
ORLISSA TAB 150MG (QL= 1 tab/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORLISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
ORLADEYO CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
orphenadrine/aspirin/cafeine tab (NORGESIC FORTE equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ORSERDU TAB (QL= 3 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORSERDU TAB 345MG (QL= 1 tab/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORTHOVISC/MONOVISIC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ORTIKOS ER CAP	-	NC	CORTICOSTEROIDS
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill, 1 fill/calendar year)	QL	G	ANTIVIRALS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill, 1 fill/calendar year)	QL	G	ANTIVIRALS
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill, 1 fill per calendar year)	QL	G	ANTIVIRALS
OSMOLEX ER TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
OSMOPREP TAB	-	NC	LAXATIVES
OSPHEA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
otomax-HC otic soln (CORTANE-B equiv)	-	NC	OTIC AGENTS
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC	OTIC AGENTS
OVACE PLUS CREAM	-	NC	DERMATOLOGICALS
OVACE PLUS LOTION	-	NC	DERMATOLOGICALS
OVACE PLUS SHAMPOO	-	NC	DERMATOLOGICALS
OVACE PLUS FOAM	-	NC	DERMATOLOGICALS
OVEEZA CAP	-	NC	HEMATOPOIETIC AGENTS
OVIDREL INJ	INF-MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
oxaprozin tab (DAYPRO equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	G	ANTIANKXIETY AGENTS
OXBRYTA TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
OXBRYTA TAB FOR ORAL SUSP (QL= 5 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
oxcarbazepine susp (TRILEPTAL equiv)	-	G	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	G	ANTICONVULSANTS
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523)	LD-PA-QL	B	OPHTHALMIC AGENTS
OXIANUJO CREAM	-	NC	DERMATOLOGICALS
oxiconazole nitrate cream (OXISTAT equiv)	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
OXISTAT CREAM	-	NC	DERMATOLOGICALS
OXISTAT LOTION	-	NC	DERMATOLOGICALS
OXTELLAR XR TAB	-	NC	ANTICONVULSANTS
oxybutynin ER tab (DITROPAN XL equiv)	-	G	URINARY ANTISPASMODICS
oxybutynin syrup	-	G	URINARY ANTISPASMODICS
oxybutynin tab (DITROPAN equiv)	-	G	URINARY ANTISPASMODICS
OXYBUTYNIN TAB	-	NC	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	G	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
OXYCODONE ER TAB (QL= 2 tabs/day)	QL	B	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
oxycodone/acetaminophen cap (TYLOX equiv)	-	G	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN	-	G	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML	-	NC	ANALGESICS - OPIOID
oxycodone/acetaminophen tab (PERCOCET equiv)	-	G	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG	-	NC	ANALGESICS - OPIOID
OXYCODONE/ASPIRIN TAB	-	G	ANALGESICS - OPIOID
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	G	ANALGESICS - OPIOID
OXYCONTIN CR TAB	-	NC	ANALGESICS - OPIOID
OXYMORPHONE ER TAB	-	NC	ANALGESICS - OPIOID
oxymorphone tab (OPANA equiv)	-	NC	ANALGESICS - OPIOID
OXYTROL PATCH (OTC)	OTC	EXC	URINARY ANTISPASMODICS
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	B	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	B	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
paliperidone ER tab (INVEGA equiv) (Step Therapy requires trial of ABILIFY or quetiapine ER)	ST	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PALYNZIQ INJ (QL= 1 inj/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PANCREAZE CAP, PERTZYE CAP, ULTRESA CAP, ZENPEP CAP	-	NC	DIGESTIVE AIDS
PANDEL CREAM	-	NC	DERMATOLOGICALS
pantoprazole EC tab (PROTONIX equiv)	-	G	ULCER DRUGS
pantoprazole sodium packet (PROTONIX equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
PARAGARD IUD	-	\$0	CONTRACEPTIVES
paramox hc gel (NOVACORT GEL equiv)	-	NC	DERMATOLOGICALS
PAREGORIC TINCTURE	-	NC	ANTIDIARRHEALS
paricalcitol cap (ZEMPLAR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
paromomycin cap (HUMATIN equiv)	-	G	AMINOGLYCOSIDES
paroxetine cap (BRISDELLE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
paroxetine ER tab (PAXIL CR equiv)	-	G	ANTIDEPRESSANTS
paroxetine oral susp (PAXIL equiv)	-	G	ANTIDEPRESSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
paroxetine tab (PAXIL equiv)	-	G	ANTIDEPRESSANTS
PAXLOVID TAB 150-100MG (QL= 20 tabs/fill)	QL	B	ANTIVIRALS
PAXLOVID TAB 300-100MG (QL= 30 tabs/fill)	QL	B	ANTIVIRALS
PAZEO OPTH SOLN 0.7%	-	NC	OPHTHALMIC AGENTS
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	LMSP-PA-QL-SF	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pb-belladonna elixir (DONNATAL equiv)	-	NC	ULCER DRUGS
PEAK FLOW METER	OTC	G	MEDICAL DEVICES AND SUPPLIES
PEDIARIX INJ	VAC	\$0	TOXOIDS
pediatric multiple vitamins/fluoride chew tab	-	G	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	G	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	G	MULTIVITAMINS
PEDIZOLPAK THERAPY PACK	-	NC	DERMATOLOGICALS
PEDVAXHIB INJ	VAC	\$0	VACCINES
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0	LAXATIVES
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES
peg 3350/electrolytes soln (NULYTELY equiv) (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0	LAXATIVES
PEGANONE TAB	-	B	ANTICONVULSANTS
PEGASYS INJ	LMSP	B	ANTIVIRALS
PEG-INTRON INJ	LMSP	B	ANTIVIRALS
PEG-PREP KIT	PA	B	LAXATIVES
PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PEN NEEDLE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
PENBRAYA INJ	VAC	\$0	VACCINES
penciclovir cream (DENA VIR equiv)	-	NC	DERMATOLOGICALS
penicillamine cap (CUPRIMINE equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
penicillamine tab (DEPEN TITRATAB equiv)	-	G	MISCELLANEOUS THERAPEUTIC CLASSES
penicillin vk tab (VEETIDS equiv)	-	G	PENICILLINS
PENLAC SOLN	-	NC	DERMATOLOGICALS
PENNSAID SOLN	-	NC	DERMATOLOGICALS
PENTACEL INJ	VAC	\$0	TOXOIDS
pentamidine neb soln (NEBUPENT equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
PENTASA CR CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
PENTASA CR CAP 250MG	-	NC	GASTROINTESTINAL AGENTS - MISC.
pentazocine/acetaminophen tab (TALACEN equiv)	-	G	ANALGESICS - OPIOID
pentazocine/naloxone tab (TALWIN NX equiv)	-	G	ANALGESICS - OPIOID
PENTOSAN CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
pentoxifylline ER tab (TRENTAL equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
PEPCID SUSP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
PERINDOPRIL TAB	-	G	ANTIHYPERTENSIVES
perindopril tab (ACEON equiv)	-	G	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
permethrin cream (ELIMITE CREAM equiv)	-	G	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PEXEVA TAB	-	NC	ANTIDEPRESSANTS
PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523)	LD	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
phenazopyridine tab (PYRIDIUM equiv)	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 95mg (AZO equiv)	OTC	EXC	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 97.5mg (AZO equiv)	OTC	EXC	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab 99.5mg (AZO equiv)	OTC	EXC	GENITOURINARY AGENTS - MISCELLANEOUS
PHENDIMETRAZINE ER TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
phendimetrazine tab (BONTRIL PDM equiv)	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
PHENELZINE SULFATE TAB	-	G	ANTIDEPRESSANTS
phenelzine tab (NARDIL equiv)	-	G	ANTIDEPRESSANTS
phenobarbital elixir	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
phenobarbital tab	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
phenoxybenzamine cap (DIBENZYLINE equiv)	-	G	ANTIHYPERTENSIVES
phenylephrine ophth soln (MYDFRIN equiv)	-	G	OPHTHALMIC AGENTS
phenytoin cap (DILANTIN equiv)	-	G	ANTICONVULSANTS
phenytoin chew tab (DILANTIN equiv)	-	G	ANTICONVULSANTS
phenytoin susp (DILANTIN equiv)	-	G	ANTICONVULSANTS
PHEXXI GEL (QL= 1 box/fill)	QL	\$0	VAGINAL AND RELATED PRODUCTS
PHOSLYRA SOLN	-	B	GASTROINTESTINAL AGENTS - MISC.
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	G	MINERALS & ELECTROLYTES
PHOSPHOLINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PHOTREXA OP KIT	-	NC	OPHTHALMIC AGENTS
PHOTREXA VISCOUS OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
phytonadione tab (MEPHYTON equiv)	-	G	VITAMINS
PICATO GEL (QL= 1 box/fill)	QL	B	DERMATOLOGICALS
PIFELTRO TAB	-	B	ANTIVIRALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	G	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older)	-	G	DERMATOLOGICALS
PIMOZIDE TAB	-	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pindolol tab (VISKEN equiv)	-	G	BETA BLOCKERS
pioglitazone tab (ACTOS equiv)	-	G	ANTIDIABETICS
pioglitazone/glimepiride tab (DUETACT equiv)	-	NC	ANTIDIABETICS
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	NC	ANTIDIABETICS
PIQRAY TAB	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	LMSP-PA-QL-SF	G	RESPIRATORY AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
PIRFENIDONE TAB	-	NC	RESPIRATORY AGENTS - MISC.
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	LMSP-PA-QL-SF	G	RESPIRATORY AGENTS - MISC.
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	LMSP-PA-QL-SF	G	RESPIRATORY AGENTS - MISC.
piroxicam cap (FELDENE equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
pitavastatin calcium tab (LIVALO equiv)	-	NC	ANTIHYPERLIPIDEMICS
PLAN B TAB	OTC	\$0	CONTRACEPTIVES
PLAVIX TAB 300MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
PLEGRIDY INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLEGRIDY PEN INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLENITY CAP	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
PLENVU SOLN	-	NC	LAXATIVES
plerixafor subcutaneous inj (MOZOBIL INJ equiv)	MSP-PA	B	HEMATOPOIETIC AGENTS
PLEXION CREAM 9.8-4.8%	-	NC	DERMATOLOGICALS
PLIAGLIS CREAM	-	NC	DERMATOLOGICALS
PLIAGLIS KIT	-	NC	DERMATOLOGICALS
PNEUMOVAX INJ	VAC	\$0	VACCINES
PODIAPN CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
PODOCON SOLN	-	B	DERMATOLOGICALS
podofilox gel (CONDYLOX equiv)	-	G	DERMATOLOGICALS
PODOFILOX SOLN	-	G	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	G	DERMATOLOGICALS
POKONZA POWDER	-	NC	MINERALS & ELECTROLYTES
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	EXC	LAXATIVES
POLYETHYLENE GLYCOL 8000 GRANULES	-	B	PHARMACEUTICAL ADJUVANTS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	G	OPHTHALMIC AGENTS
POLY-TUSSIN DM SYRUP	-	NC	COUGH/COLD/ALLERGY
POLY-VI-FLOR CHEW 0.25MG	-	NC	MULTIVITAMINS
POLY-VI-FLOR CHEW 0.5MG	-	NC	MULTIVITAMINS
POLY-VI-FLOR CHEW 1MG	-	NC	MULTIVITAMINS
POLY-VI-FLOR CHEW W/IRON	-	NC	MULTIVITAMINS
POLY-VI-FLOR SUSP	-	NC	MULTIVITAMINS
POMALYST CAP (QL= 21 caps/28 days)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PONVORY TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PONVORY TAB STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
posaconazole DR tab (NOXAFIL equiv) (QL= 93 tabs/30 days)	PA-QL	G	ANTIFUNGALS
posaconazole susp (NOXAFIL equiv) (QL= 525ml/26 days)	PA-QL	G	ANTIFUNGALS
POT/CHLORIDE EFFER TAB	-	G	MINERALS & ELECTROLYTES
POTABA POWDER PACKET	-	B	VITAMINS
potassium bicarbonate effer tab (K-LYTE equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride effer tab (K-LYTE/CL equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride ER cap (MICRO-K equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride ER tab (K-TAB equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride micro tab (K-DUR equiv)	-	G	MINERALS & ELECTROLYTES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
potassium chloride powder packet (KLOR-CON equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride soln	-	G	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE TAB ER	-	G	MINERALS & ELECTROLYTES
potassium citrate CR tab (UROCIT-K TAB equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
potassium iodide oral soln (SSKI equiv)	-	G	COUGH/COLD/ALLERGY
potassium phosphate monobasic tab (K-PHOS equiv)	-	G	MINERALS & ELECTROLYTES
POTIGA TAB (QL= 3 tabs/day)	QL	B	ANTICONVULSANTS
PRADAXA PELLETT PACK	-	NC	ANTICOAGULANTS
pramipexole ER tab (MIRAPEX ER equiv)	-	G	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	G	ANTIPARKINSON AGENTS
PRAMOSONE CREAM 1-1%	-	NC	DERMATOLOGICALS
PRAMOSONE CREAM 1-2.5%	-	NC	DERMATOLOGICALS
PRAMOSONE E CREAM	-	B	DERMATOLOGICALS
PRAMOSONE LOTION	-	NC	DERMATOLOGICALS
PRAMOSONE OINT	-	NC	DERMATOLOGICALS
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	G	ANORECTAL AGENTS
PRANDIMET TAB	-	NC	ANTIDIABETICS
PRASCION RA CREAM	-	B	DERMATOLOGICALS
prasugrel tab (EFFIENT equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
pravastatin tab (PRAVACHOL equiv)	-	\$0	ANTIHYPERTENSIVES
praziquantel tab (BILTRICIDE equiv)	-	G	ANTHELMINTICS
prazosin cap (MINIPRESS equiv)	-	G	ANTIHYPERTENSIVES
PRECISION XTRA KETONE TEST STRIP	OTC	NC	DIAGNOSTIC PRODUCTS
PRECISION XTRA METER	-	NC	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA TEST STRIP	--OTC	NC	DIAGNOSTIC PRODUCTS
PRED FORTE OPHTH SUSP	-	B	OPHTHALMIC AGENTS
PRED MILD OPHTH SOLN	-	B	OPHTHALMIC AGENTS
PRED-G OPHTH SOLN	-	B	OPHTHALMIC AGENTS
PREDNICARBATE CREAM	-	B	DERMATOLOGICALS
PREDNICARBATE OIN	-	B	DERMATOLOGICALS
prednisolone ODT (ORAPRED equiv)	-	NC	CORTICOSTEROIDS
PREDNISOLONE ODT TAB	-	NC	CORTICOSTEROIDS
PREDNISOLONE OPHTH SUSP	-	G	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
PREDNISOLONE SOLN	-	B	CORTICOSTEROIDS
prednisolone soln	-	G	CORTICOSTEROIDS
prednisolone soln (PEDIAPRED equiv)	-	G	CORTICOSTEROIDS
prednisolone tab (MILLIPRED equiv)	-	NC	CORTICOSTEROIDS
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/NEPAFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
prednisone pack	-	NC	CORTICOSTEROIDS
PREDNISONE SOLN	-	B	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	G	CORTICOSTEROIDS
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC	CORTICOSTEROIDS
PREFERA OB	-	NC	MULTIVITAMINS
PREFERA OB ONE	-	NC	MULTIVITAMINS
PREFEST TAB	-	B	ESTROGENS
pregabalin cap (LYRICA equiv) (QL= 3 caps/day)	QL	G	ANTICONVULSANTS
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	G	ANTICONVULSANTS
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	G	ANTICONVULSANTS
pregabalin ER tab (LYRICA CR equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	G	ANTICONVULSANTS
PREGEN DHA CAP	-	NC	MULTIVITAMINS
PREGENNA TAB	-	NC	MULTIVITAMINS
PREHEVBRIO SUSP	VAC	\$0	VACCINES
PREMARIN TAB	-	B	ESTROGENS
PREMARIN VAGINAL CREAM	-	NC	VAGINAL PRODUCTS
PREMPHASE TAB, PREMPRO TAB	-	B	ESTROGENS
PRENA1 CHEW	-	NC	MULTIVITAMINS
PRENA1 PEARL, VITAPEARL	-	NC	MULTIVITAMINS
PRENA1 TRUE, VITATRUE	-	NC	MULTIVITAMINS
PRENARA CAP	-	NC	MULTIVITAMINS
PRENATA	-	G	MULTIVITAMINS
PRENATABS RX TAB	-	G	MULTIVITAMINS
PRENATAL 19 CHEW TAB	-	G	MULTIVITAMINS
PRENATAL 19 TAB	-	G	MULTIVITAMINS
PRENATAL FORMULA, PRENATAL MULTI + DHA	-	G	MULTIVITAMINS
PRENATAL MULTIVITAMIN + D	-	G	MULTIVITAMINS
PRENATAL PLUS IRON	-	G	MULTIVITAMINS
PRENATAL VITAMINS (NON-PREFERRED)	-	B	MULTIVITAMINS
PRENATE AM	-	NC	MULTIVITAMINS
PRENATE CHEWABLE	-	NC	MULTIVITAMINS
PRENATE DHA	-	NC	MULTIVITAMINS
PRENATE ELITE	-	NC	MULTIVITAMINS
PRENATE ESSENTIAL	-	NC	MULTIVITAMINS
PRENATE MINI	-	NC	MULTIVITAMINS
PRENATE MINI, TRISTART DHA	-	NC	MULTIVITAMINS
PRENATE TAB	-	NC	MULTIVITAMINS
PRENATRIX TAB	-	NC	MULTIVITAMINS
PRENATRYL TAB	-	NC	MULTIVITAMINS
PRESTALIA TAB	-	NC	ANTIHYPERTENSIVES
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTIMYCOBACTERIAL AGENTS
PREVACID CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
PREVACID OTC CAP	OTC	EXC	ULCER DRUGS
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
PREVIDENT PASTE	-	B	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT SOLN	-	B	MOUTH/THROAT/DENTAL AGENTS
PREVNAR 13 INJ	VAC	\$0	VACCINES
PREVNAR 20 INJ (Covered for members age 19 years or older)	VAC	\$0	VACCINES
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	LMSP-PA-QL	B	ANTIVIRALS
PREZCOBIX TAB	-	B	ANTIVIRALS
PREZISTA SUSP	-	B	ANTIVIRALS
PREZISTA TAB	-	B	ANTIVIRALS
PRIFTIN TAB	-	B	ANTIMYCOBACTERIAL AGENTS
PRILOSEC CAP	-	NC	ULCER DRUGS
PRILOSEC OTC DR TAB	OTC	EXC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
PRILOSEC OTC DR TAB	OTC	NC	ULCER DRUGS
PRIMACARE	-	NC	MULTIVITAMINS
primaquine tab (PRIMAQUINE equiv)	-	G	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	G	ANTICONVULSANTS
PRIMIDONE TAB	-	NC	ANTICONVULSANTS
PRIMLEV TAB 10-300MG	-	NC	ANALGESICS - OPIOID
PRIMLEV TAB 5-300MG	-	NC	ANALGESICS - OPIOID
PRIMSOL SOLN	-	B	ANTI-INFECTIVE AGENTS - MISC.
PRIORIX INJ	VAC	\$0	VACCINES
probenecid tab (BENEMID equiv)	-	G	GOUT AGENTS
prochlorperazine supp (COMPAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PROCRIT INJ	-	NC	HEMATOPOIETIC AGENTS
PROCTOCORT SUPP	-	NC	ANORECTAL AGENTS
PROCTOFOAM HC FOAM	-	B	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	G	ANORECTAL AGENTS
PROCYSBI CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PROCYSBI GRANULES PACKET	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PRODRIN TAB	-	NC	MIGRAINE PRODUCTS
progesterone cap (PROMETRIUM equiv)	-	G	PROGESTINS
progesterone oil inj	-	G	PROGESTINS
PROGESTERONE SUPP	PA	B	VAGINAL PRODUCTS
PROGRAF PACKET	-	NC	MISCELLANEOUS THERAPEUTIC CLASSE
PROLATE TAB 7.5-300MG	-	NC	ANALGESICS - OPIOID
PROLENSA OPHTH SOLN	-	B	OPHTHALMIC AGENTS
PROLIA INJ (QL= 1 fill/6 months)	LMSP-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PROMACTA POWDER	LMSP-PA	B	HEMATOPOIETIC AGENTS
PROMACTA TAB	LMSP-PA	B	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	G	COUGH/COLD/ALLERGY
promethazine supp (PHENERGAN equiv)	-	G	ANTIHISTAMINES
promethazine syrup	-	G	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	G	ANTIHISTAMINES
PROMETHAZINE VC SYRUP	-	G	COUGH/COLD/ALLERGY
promethazine VC syrup (PHENERGAN VC equiv)	-	G	COUGH/COLD/ALLERGY

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
PROMETHAZINE VC/CODEINE SYRUP	-	G	COUGH/COLD/ALLERGY
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	G	COUGH/COLD/ALLERGY
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	G	COUGH/COLD/ALLERGY
PROMETHEGAN SUPP	-	G	ANTIHISTAMINES
PROMISEB CREAM	-	NC	DERMATOLOGICALS
propafenone ER cap (RYTHMOL SR equiv)	-	G	ANTIARRHYTHMICS
propafenone tab (RYTHMOL equiv)	-	G	ANTIARRHYTHMICS
PROPANTHELINE TAB	-	B	ULCER DRUGS
proparacaine ophth soln (ALCAINE equiv)	-	G	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	G	BETA BLOCKERS
propranolol oral soln 20mg/5ml (PROPRANOLOL equiv)	-	G	BETA BLOCKERS
PROPRANOLOL SOLN	-	G	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	G	BETA BLOCKERS
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	G	ANTIHYPERTENSIVES
propylthiouracil tab	-	G	THYROID AGENTS
PROQUAD INJ	VAC	\$0	VACCINES
PROQUIN XR TAB	-	NC	FLUOROQUINOLONES
PROSED DS TAB	-	NC	URINARY ANTI-INFECTIVES
PROTHELIAL PASTE	-	NC	MOUTH/THROAT/DENTAL AGENTS
protriptyline tab (VIVACTIL equiv)	-	G	ANTIDEPRESSANTS
PROVIDA DHA	-	NC	MULTIVITAMINS
PROVIDA OB	-	NC	MULTIVITAMINS
PROVIGIL TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
PROZAC WEEKLY CAP	-	NC	ANTIDEPRESSANTS
PROZENA PAD	-	NC	DERMATOLOGICALS
PULMICORT FLEXHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMOZYME INH SOLN	LMSP	B	RESPIRATORY AGENTS - MISC.
PUREFOLIX TAB	-	NC	HEMATOPOIETIC AGENTS
PURIXAN SUSP (Members age 9 or older require Prior Authorization)	PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PYLERA CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
pyrazinamide tab	-	G	ANTIMYCOBACTERIAL AGENTS
PYRIDIUM TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
pyridostigmine CR tab (MESTINON equiv)	-	G	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	G	ANTIMYASTHENIC/CHOLINERGIC AGENTS
PYRIDOSTIGMINE TAB 30MG	-	NC	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyridoxine inj	-	G	VITAMINS
pyridstigmine soln (MESTINON equiv)	-	G	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	G	ANTIMALARIALS
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC	ANTIMALARIALS
PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
QBRELIS SOLN (Prior Authorization required for members age 9 or older)	PA	B	ANTIHYPERTENSIVES
QBREXZA PAD	-	NC	DERMATOLOGICALS
QDOLO SOLN, TRAMADOL SOLN	-	NC	ANALGESICS - OPIOID
QELBREE ER CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
QMIIZ ODT TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
QNASL NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
QTERN TAB	-	NC	ANTIDIABETICS
QUALAQUIN CAP	-	NC	ANTIMALARIALS
QUDEXY XR CAP	-	NC	ANTICONVULSANTS
quetiapine tab (SEROQUEL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
QUETIAPINE TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
QUFLORA PEDIATRIC CHEW TAB	-	B	MULTIVITAMINS
QUILLICHEW ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
QUILLIVANT XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
quinapril tab (ACCUPRIL equiv)	-	G	ANTIHYPERTENSIVES
QUINAPRIL/HCTZ TAB	-	G	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	G	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	G	ANTIARRHYTHMICS
quinidine sulfate tab	-	G	ANTIARRHYTHMICS
QUINIDINE SULFATE TAB	-	NC	ANTIARRHYTHMICS
quinine sulfate cap (QUALAQUIN equiv)	-	NC	ANTIMALARIALS
QUINIXIL PAK	-	NC	DERMATOLOGICALS
QULIPTA TAB	-	NC	MIGRAINE PRODUCTS
QUVIVIQ TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
QVAR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
QVAR REDIHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
RABAVERT INJ	VAC	EXC	VACCINES
rabeprazole EC tab (ACIPHEX equiv)	PA	G	ULCER DRUGS
RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
RAGWITEK SL TAB	-	NC	BIOLOGICALS MISC
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	PA-QL	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ramipril cap (ALTACE equiv)	-	G	ANTIHYPERTENSIVES
ranitidine cap (ZANTAC equiv)	-	NC	ULCER DRUGS
ranitidine syrup (ZANTAC equiv)	-	NC	ULCER DRUGS
ranitidine tab (Rx Only) (ZANTAC equiv)	-	NC	ULCER DRUGS
ranolazine tab (RANEXA equiv)	-	G	ANTIANGINAL AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
rasagiline tab (AZILECT equiv)	¢	G	ANTIPARKINSON AGENTS
RAVICTI LIQUID	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYALDEE CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYOS TAB	-	NC	CORTICOSTEROIDS
REBETOL SOLN	LMSP	B	ANTIVIRALS
REBIF INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REBLOZYL INJ	-	NC	HEMATOPOIETIC AGENTS
RECOMBINATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
RECORLEV TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RECTIV OINT	-	B	ANORECTAL AGENTS
REDITREX INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
REGRANEX GEL (QL= 30gm/fill)	QL	B	DERMATOLOGICALS
RELAFEN DS TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
RELENZA DISKHALER (QL= 1 inhaler/calendar year)	QL	B	ANTIVIRALS
RELEUKO INJ	-	NC	HEMATOPOIETIC AGENTS
RELEUKO PREFILLED SYRINGE INJ	-	NC	HEMATOPOIETIC AGENTS
RELEXXI ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
RELISTOR INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR INJ KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELPAX TAB	-	NC	MIGRAINE PRODUCTS
RELTONE CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELYVRIO PAK (QL= 2 packets/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
REMEDIENT CAP	-	NC	MULTIVITAMINS
REMICADE INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
RENAGEL TAB 800MG	-	NC	GASTROINTESTINAL AGENTS - MISC.
renaphro cap (NEPHROCAP equiv)	-	G	MULTIVITAMINS
RENFLEXIS INJ	MSP-PA	B	GASTROINTESTINAL AGENTS - MISC.
RENOVA CREAM	-	EXC	DERMATOLOGICALS
RENVELA TAB	-	B	GASTROINTESTINAL AGENTS - MISC.
repaglinide tab (PRANDIN equiv)	-	G	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	B	ANTIHYPERLIPIDEMICS
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	B	ANTIHYPERLIPIDEMICS
REQUIP XL TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
RESCRIPTOR TAB	-	B	ANTIVIRALS
RESERVAPAK SYRUP	-	NC	ALTERNATIVE MEDICINES
RESTASIS MULTI-DOSE	-	NC	OPHTHALMIC AGENTS
RESTASIS OPHTH EMULSION	-	NC	OPHTHALMIC AGENTS
RETACRIT INJ	LMSP	B	HEMATOPOIETIC AGENTS
RETEVMO CAP (QL= 4 caps/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETIN-A CREAM	-	NC	DERMATOLOGICALS
RETIN-A GEL	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
RETIN-A MICRO GEL 0.04%, 0.1%	-	NC	DERMATOLOGICALS
RETIN-A MICRO GEL 0.08%, 0.06%	-	NC	DERMATOLOGICALS
REVATIO SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
REVLIMID CAP (QL= 1 cap/day; Only available through Walgreens 888-347-3416; Restricted to Oncology or Hematology Specialist)	LD-QL-RS	B	MISCELLANEOUS THERAPEUTIC CLASSES
REXAPHENAC CREAM	-	NC	DERMATOLOGICALS
REXULTI TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
REYATAZ POWDER PACK	-	B	ANTIVIRALS
REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS
REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
REZVOGLAR INJ	-	NC	ANTIDIABETICS
REZYST CHEW TAB	-	NC	ANTIDIARRHEALS
RHEUMATREX TAB	-	B	ANALGESICS - ANTI-INFLAMMATORY
RHOFADE CREAM	-	EXC	DERMATOLOGICALS
RHOPRESSA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
RIASTAP INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
RIBAPAK TAB	-	NC	ANTIVIRALS
RIBAVIRIN CAP	LMSP	B	ANTIVIRALS
ribavirin cap (REBETOL equiv)	LMSP	G	ANTIVIRALS
ribavirin inh soln (VIRAZOLE equiv)	-	NC	ANTIVIRALS
RIBAVIRIN TAB	LMSP	B	ANTIVIRALS
RIBAVIRIN TAB 400MG	-	NC	ANTIVIRALS
RIDAURA CAP	-	B	ANALGESICS - ANTI-INFLAMMATORY
rifabutin cap (MYCOBUTIN equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
RIFAMATE CAP	-	B	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
riluzole tab (RILUTEK equiv)	-	G	NEUROMUSCULAR AGENTS
RIMANTADINE TAB	-	NC	ANTIVIRALS
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
RIOMET ER SUSP	PA	B	ANTIDIABETICS
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
risedronate tab (ACTONEL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
RISPERIDONE ODT	-	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone ODT (RISPERDAL M equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone soln (RISPERDAL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone tab (RISPERDAL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ritonavir tab (NORVIR equiv)	-	G	ANTIVIRALS
RITUXAN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
rivastigmine cap (EXELON equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rivastigmine patch (EXELON equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RIVFLOZA INJ	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G	MIGRAINE PRODUCTS
ROAOXIA GEL	-	NC	DERMATOLOGICALS
ROCKLATAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
roflumilast tab	PA	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ropinirole ER tab (REQUIP XL equiv)	-	G	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	G	ANTIPARKINSON AGENTS
ROPIVICAINE/CLONIDINE/KETOROLAC INJ	-	NC	LOCAL ANESTHETICS-PARENTERAL
ROSADAN KIT	-	NC	DERMATOLOGICALS
rosuvastatin tab (CRESTOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
ROSZET TAB	-	NC	ANTIHYPERLIPIDEMICS
ROTARIX SUSP	VAC	\$0	VACCINES
ROTATEQ INJ	VAC	\$0	VACCINES
ROWASA KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
ROXYBOND TAB	-	NC	ANALGESICS - OPIOID
ROZEREM TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ROZLYTREK CAP (QL= 3 caps/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ROZLYTREK PAK (QL= 6 packs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
rufinamide susp (BANZEL equiv)	PA	G	ANTICONSULSANTS
rufinamide tab (BANZEL equiv)	PA	G	ANTICONSULSANTS
RUKOBIA ER TAB (Restricted to Infectious Disease Specialist)	RS	B	ANTIVIRALS
RYALTRIS SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
RYBIX ODT	-	NC	ANALGESICS - OPIOID
RYCLORA SOLN	-	NC	ANTIHISTAMINES
RYDAPT CAP (QL= 56 caps/28 days)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RYTARY CAP	-	NC	ANTIPARKINSON AGENTS
RYVENT TAB	-	NC	ANTIHISTAMINES
SABRIL TAB	-	NC	ANTICONSULSANTS
SAFYRAL TAB	-	NC	CONTRACEPTIVES
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SALEX LOTION KIT	-	NC	DERMATOLOGICALS
SALEX SHAMPOO	-	B	DERMATOLOGICALS
SALICATE LIQUID	-	NC	DERMATOLOGICALS
salicyclic acid soln	-	NC	DERMATOLOGICALS
salicylic acid cream (CERAVE PSORIASIS equiv)	-	NC	DERMATOLOGICALS
salicylic acid shampoo (SALEX equiv)	-	G	DERMATOLOGICALS
SALIMEZ FORTE CREAM	-	NC	DERMATOLOGICALS
salsalate tab (DISALCID equiv)	-	G	ANALGESICS - NONNARCOTIC
SANCUSO PATCH (QL= 4 patches/fill)	QL	B	ANTIEMETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
SANDIMMUNE SOLN 100MG/ML	-	B	ASSORTED CLASSES
SANDOSTATIN LAR INJ KIT	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SANTYL OINT (QL= 90gm/30 days)	QL	B	DERMATOLOGICALS
sapropterin dihydrochloride powder packet (KUVAN equiv)	LMSP-PA	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
sapropterin dihydrochloride soluble tab (KUVAN equiv)	LMSP-PA	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
SARAFEM TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVAYSA TAB	-	NC	ANTICOAGULANTS
SAVELLA PAK	-	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB (QL= 2 tabs/day)	QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
saxagliptin hcl tab (ONGLYZA equiv)	-	NC	ANTIDIABETICS
saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv)	-	NC	ANTIDIABETICS
SCARCIN GEL	-	NC	DERMATOLOGICALS
scarcin gel (SCARCIN equiv)	-	NC	DERMATOLOGICALS
SCARCIN LIQUID ROLL-ON	-	NC	DERMATOLOGICALS
SCEMBLIX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
scopolamine patch (TRANSDERM-SCOP equiv)	-	G	ANTIEMETICS
SECONAL CAP	-	B	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
SECUADO PATCH	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SEEBRI NEOHALER CAP	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SEGLENTIS TAB	-	NC	ANALGESICS - OPIOID
SEGLUROMET TAB	-	NC	ANTIDIABETICS
SELECT OB + DHA	-	NC	MULTIVITAMINS
selegiline cap (ELDEPRYL equiv)	-	G	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	G	ANTIPARKINSON AGENTS
selenium sulfide lotion	OTC	EXC	DERMATOLOGICALS
selenium sulfide lotion 2.5% (SELSUN equiv)	-	G	DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	G	DERMATOLOGICALS
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC	DERMATOLOGICALS
SELZENTRY SOLN	-	B	ANTIVIRALS
SELZENTRY TAB	-	B	ANTIVIRALS
SEMGLEE INJ (SINGLE PEN)	-	NC	ANTIDIABETICS
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	B	ANTIDIABETICS
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	B	ANTIDIABETICS
SEMGLEE SOLN	-	NC	ANTIDIABETICS
SEMPREX-D CAP	-	EXC	COUGH/COLD/ALLERGY
SENSIPAR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SEREVENT DISKUS INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SERNIVO SPRAY	-	NC	DERMATOLOGICALS
SEROQUEL XR TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SERTRALINE CAP	-	NC	ANTIDEPRESSANTS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF Infertility	LD Limited Distribution
PA	Plan Exclusion	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL Quantity Limit	RDX Restricted to Diagnosis
ST	Prior Authorization	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
	Restricted to Specialist	VAC Vaccine Program	¢ RxCENTS
	Step Therapy		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
sertraline conc (ZOLOFT equiv)	-	G	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	G	ANTIDEPRESSANTS
sevelamer hydrochloride tab (RENAGEL equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
sevelamer powder pak (RENVELA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (RENVELA TAB equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
SEYSARA TAB	-	NC	TETRACYCLINES
SHINGRIX INJ (Covered for members age 19 years or older)	VAC	\$0	VACCINES
SIGNIFOR INJ (QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SIKLOS TAB	-	NC	HEMATOPOIETIC AGENTS
SILALITE PAK MIS	-	NC	DERMATOLOGICALS
SILATRIX GEL	-	NC	MOUTH/THROAT/DENTAL AGENTS
sildenafil susp (REVATIO equiv) (Members age 9 or older require Prior Authorization)	PA	G	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab (VIAGRA equiv) (QL=6 tabs/30 days)	QL	G	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab 20mg (REVATIO equiv)	PA	G	CARDIOVASCULAR AGENTS - MISC.
SILIPAC KIT	-	NC	DERMATOLOGICALS
SILIQ INJ	-	NC	DERMATOLOGICALS
silodosin cap (RAPAFLO equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	G	DERMATOLOGICALS
SILVERA PAD	-	NC	DERMATOLOGICALS
SIMBRINZA OPHTH SUSP	-	B	OPHTHALMIC AGENTS
SIMPONI ARIA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI AUTO-INJECTOR 50MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 50MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0	ANTIHYPERTENSIVES
simvastatin tab 80mg (ZOCOR equiv)	-	NC	ANTIHYPERTENSIVES
sirolimus soln (RAPAMUNE equiv)	-	G	MISCELLANEOUS THERAPEUTIC CLASSES
sirolimus tab (RAPAMUNE equiv)	-	G	ASSORTED CLASSES
SIRTURO TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
SITAVIG TAB	-	NC	ANTIVIRALS
SITZMARKS CAP	-	NC	DIAGNOSTIC PRODUCTS
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTI-INFECTIVE AGENTS - MISC.
SKLICE LOTION	-	NC	DERMATOLOGICALS
SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 75MG/0.83ML (QL= 2 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
SKYTROFA INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SLYND TAB	-	NC	CONTRACEPTIVES
smz/tmp (DS) tab (BACTRIM DS equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
SOAANZ TAB	-	NC	DIURETICS
sodium chloride neb soln (HYPER-SAL equiv)	-	G	COUGH/COLD/ALLERGY

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
sodium citrate/citric acid soln (BICITRA equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride chew tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride paste (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride rinse (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
SODIUM HYALU INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SODIUM IODIDE I-131 SOLN	-	NC	THYROID AGENTS
SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
sodium phenylbutyrate powder (BUPHENYL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium phenylbutyrate tab (BUPHENYL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	G	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	G	ASSORTED CLASSES
sodium sulfacetamide gel (OVACE equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide lotion (KLARON equiv)	-	G	DERMATOLOGICALS
sodium sulfacetamide shampoo (OVACE equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	G	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	G	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	G	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion 10-1% (ROSAC WASH equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	G	DERMATOLOGICALS
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR SUSP	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur susp (PLEXION TS equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC	DERMATOLOGICALS
sodium/magnesium/potassium soln (SUPREP equiv) (QL= 2 fills/calendar year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0	LAXATIVES
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANTIVIRALS
SOGROYA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOHONOS CAP	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOLAICE PATCH	-	NC	DERMATOLOGICALS
SOLARAVIX PAK	-	NC	DERMATOLOGICALS
solifenacin tab (VESICARE equiv)	-	G	URINARY ANTISPASMODICS
SOLIQUA INJ (QL= 15ml/25 days)	QL	B	ANTIDIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
SOLOSEC GRANULES PACKET	-	NC	AMEBICIDES
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	B	CORTICOSTEROIDS
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	B	CORTICOSTEROIDS
SOLU-MEDROL INJ	-	NC	CORTICOSTEROIDS
SOLU-MEDROL INJ 2GM	-	B	CORTICOSTEROIDS
SOLU-MEDROL PF INJ	-	NC	CORTICOSTEROIDS
SOMA TAB 250MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOMAVERT INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOOLANTRA CREAM	-	NC	DERMATOLOGICALS
sorafenib tosylate tab (NEXAVAR equiv)	LMSP-PA-SF	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
sotalol AF tab (BETAPACE AF equiv)	-	G	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	G	BETA BLOCKERS
SOTYKTU TAB	-	NC	DERMATOLOGICALS
SOTYLIZE SOLN	-	NC	BETA BLOCKERS
SOTYLIZE SOLN 5MG/ML (Prior Authorization required for members age 9 or older)	PA	B	BETA BLOCKERS
SOVALDI PELLETT PAK	-	NC	ANTIVIRALS
SOVALDI TAB	-	NC	ANTIVIRALS
SPECTRACEF TAB	-	B	CEPHALOSPORINS
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	\$0	VACCINES
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	\$0	VACCINES
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	B	DERMATOLOGICALS
SPIRIVA HANDIHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL))	QL-ST	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 or older)	PA	G	DIURETICS
spironolactone tab (ALDACTONE equiv)	-	G	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	G	DIURETICS
SPORANOX CAP	-	NC	ANTIFUNGALS
SPORANOX SOLN	PA	B	ANTIFUNGALS
SPRAVATO NASAL SOLN	-	NC	ANTIDEPRESSANTS
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	\$0	CONTRACEPTIVES
SPRITAM TAB	-	NC	ANTICONSULSANTS
SPRIX NASAL SPRAY	PA	B	ANALGESICS - ANTI-INFLAMMATORY
SPRYCEL TAB	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SPS SUSP	-	G	MISCELLANEOUS THERAPEUTIC CLASSES
SSKI ORAL SOLN	-	B	COUGH/COLD/ALLERGY
STAVUDINE CAP	-	G	ANTIVIRALS
stavudine cap (ZERIT equiv)	-	G	ANTIVIRALS
STAVZOR CAP	-	NC	ANTICONSULSANTS
STEGLATRO TAB	-	NC	ANTI-DIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
STEGLUJAN TAB	-	NC	ANTIDIABETICS
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
STENDRA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
STIMATE NASAL SOLN	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
STIMUFEND INJ	-	NC	HEMATOPOIETIC AGENTS
STIOLTO INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIANT FILM	-	NC	ANDROGENS-ANABOLIC
STRIBILD TAB	-	B	ANTIVIRALS
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SUBLOCADE SOLN	-	NC	ANALGESICS - OPIOID
SUBOXONE SL FILM	-	NC	ANALGESICS - OPIOID
SUBSYS SPRAY	-	NC	ANALGESICS - OPIOID
SUCRAID SOLN	-	NC	DIGESTIVE AIDS
sucrafate susp (CARAFATE equiv)	PA	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS
sucrafate tab (CARAFATE equiv)	-	G	ULCER DRUGS
SUFLAVE SOLN (QL= 2 fills/calendar year)	QL	B	LAXATIVES
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	G	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	G	OPHTHALMIC AGENTS
sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv)	-	NC	DERMATOLOGICALS
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	NC	DERMATOLOGICALS
sulfacetamide sodium/sulfur cream 9.8-4.8% (PLEXION equiv)	-	NC	DERMATOLOGICALS
sulfadiazine tab	-	G	SULFONAMIDES
SULFADIAZINE TAB	-	NC	SULFONAMIDES
SULFAMYLON CREAM	-	B	DERMATOLOGICALS
sulfasalazine EC tab (AZULFIDINE equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
sulfasalazine tab (AZULFIDINE equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
sulindac tab (CLINORIL equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
SUMADAN WASH 9-4.5%	-	NC	DERMATOLOGICALS
SUMADEN XLT KIT	-	NC	DERMATOLOGICALS
SUMANSETRON PAK	-	NC	MIGRAINE PRODUCTS
SUMATRIPTAN INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan/naproxen tab (Treximet equiv)	-	NC	MIGRAINE PRODUCTS
SUMAVEL DOSEPRO INJ	-	NC	MIGRAINE PRODUCTS
SUMAXIN WASH	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
sunitinib malate cap (SUTENT equiv)	LMSP-PA-SF	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SUNLENCA TAB	-	NC	ANTIVIRALS
SUNOSI TAB (QL= 1 tab/day)	PA-QL	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
SUPPRELIN LA INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SUPRAX CAP	-	B	CEPHALOSPORINS
SUPRAX CHEW TAB	-	B	CEPHALOSPORINS
SUPRAX SUSP 500MG/5ML	-	B	CEPHALOSPORINS
SUPREP BOWEL PREP PACK	-	NC	LAXATIVES
SUSTIVA TAB	-	B	ANTIVIRALS
SUSTOL INJ	-	NC	ANTIEMETICS
SUTAB TAB	-	NC	LAXATIVES
SUTENT CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYLATRON INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYMAX DUOTAB	-	B	ULCER DRUGS
SYMBICORT INHALER	-	NC	ASTHMA AND BRONCHODILATOR AGENTS
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	B	ANTIVIRALS
SYMLINPEN INJ	PA	B	ANTIDIABETICS
SYMPAZAN ORAL FILM	-	NC	ANTICONVULSANTS
SYMPROIC TAB	PA	B	GASTROINTESTINAL AGENTS - MISC.
SYMTUZA TAB	-	B	ANTIVIRALS
SYNAREL NASAL SOLN	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SYNDROS SOLN	-	NC	ANTIEMETICS
SYNJARDY TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	B	ANTIDIABETICS
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
SYNTHROID TAB	-	NC	THYROID AGENTS
SYNVEXIA TC CREAM	-	NC	DERMATOLOGICALS
TABLOID TAB	-	B	ANTINEOPLASTICS
TABRECTA TAB (QL= 4 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TACLONEX SUSP	-	NC	DERMATOLOGICALS
tacrolimus cap (PROGRAF equiv)	-	G	ASSORTED CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	G	DERMATOLOGICALS
tadalafil tab (CIALIS equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	G	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day)	QL	G	CARDIOVASCULAR AGENTS - MISC.
TADLIQ SUSP (Members age 9 years or older require Prior Authorization)	MSP-PA	B	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAFINLAR TAB	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tafluprost preservative free (pf) ophth soln (ZIOPTAN OPHTH SOLN equiv)	-	NC	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumericera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
TALICIA CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
TALZENNA CAP 0.1MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.35MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
TANZEUM INJ	-	NC	ANTIDIABETICS
TARCEVA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGRETIN GEL	-	NC	DERMATOLOGICALS
TARPEYO CAP	-	NC	CORTICOSTEROIDS
TASCENSO ODT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TASIGNA CAP	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tasimelteon cap (HETLIOZ equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
TASOPROL CREAM KIT	-	NC	DERMATOLOGICALS
tavaborole soln (KERYDIN equiv)	-	NC	DERMATOLOGICALS
TAVALISSE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	HEMATOLOGICAL AGENTS - MISC.
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
TAYTULLA CAP	-	NC	CONTRACEPTIVES
tazarotene cream 0.1% (TAZORAC equiv)	PA	G	DERMATOLOGICALS
tazarotene gel (TAZORAC equiv)	-	NC	DERMATOLOGICALS
TAZORAC CREAM	-	NC	DERMATOLOGICALS
TAZORAC CREAM 0.05%	PA	B	DERMATOLOGICALS
TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TECFIDERA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECFIDERA STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECHNIVIE TAB	-	NC	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
TEGSEDI INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TEKTURN HCT TAB (Step Therapy requires trial of valsartan/hctz)	ST	B	ANTIHYPERTENSIVES
telmisartan tab (MICARDIS equiv)	-	G	ANTIHYPERTENSIVES
TELMISARTAN/AMLODIPINE TAB	-	NC	ANTIHYPERTENSIVES
telmisartan/amlodipine tab (TWINSTA equiv)	-	NC	ANTIHYPERTENSIVES
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
temazepam cap 22.5mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
temazepam cap 7.5mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
TEMOVATE CREAM	-	NC	DERMATOLOGICALS
TEMOVATE OINT	-	NC	DERMATOLOGICALS
temozolomide cap (TEMODAR equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
temsirolimus inj (TORISEL equiv)	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	G	ANTIVIRALS
TEPMETKO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
terazosin cap (HYTRIN equiv)	-	G	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv)	-	G	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	G	VAGINAL PRODUCTS
TERCONAZOLE CREAM 0.8%	-	G	VAGINAL PRODUCTS
terconazole supp (TERAZOL equiv)	-	G	VAGINAL PRODUCTS
teriflunomide tab (AUBAGIO equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
teriparatide (recombinant) soln pen-inj 600mcg/2.4ml (FORTEO equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TERIPARATIDE INJ 620MCG/2.48ML	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
TEST STRIP (all other test strips)	OTC-PA	B	DIAGNOSTIC PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	G	ANDROGENS-ANABOLIC
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	B	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 25MG	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1% 25mg (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1% 50mg (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1% pump (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 2% (FORTESTA equiv)	-	NC	ANDROGENS-ANABOLIC
TESTOSTERONE GEL PUMP	-	NC	ANDROGENS-ANABOLIC
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	G	ANDROGENS-ANABOLIC
TESTOSTERONE GEL, VOGELXO GEL	-	NC	ANDROGENS-ANABOLIC
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	G	ANDROGENS-ANABOLIC

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
TETANUS-DIPHTHERIA TOXOID INJ	VAC	\$0	TOXOIDS
tetrabenazine tab (XENAZINE equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracycline cap	-	G	TETRACYCLINES
TETRACYCLINE TAB	-	NC	TETRACYCLINES
TEZSPIRE INJ (QL= 1 pen/28 days)	LMSP-PA-QL	B	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
THALITONE TAB	-	NC	DIURETICS
THALOMID CAP	MSP	B	ASSORTED CLASSES
theophylline er tab (THEOPHYLLINE ER equiv)	-	G	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	G	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	G	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
THEOPHYLLINE TAB ER	-	B	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
THIOLA EC TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
thioridazine tab (MELLARIL equiv)	-	G	ANTI-PSYCHOTICS/ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	G	ANTI-PSYCHOTICS/ANTIMANIC AGENTS
THRIVITE RX	-	NC	MULTIVITAMINS
THYQUIDITY SOLN	-	NC	THYROID AGENTS
THYROLAR TAB	-	B	THYROID AGENTS
tiagabine tab (GABITRIL equiv)	-	G	ANTICONVULSANTS
TIBSOVO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TICANASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
TIGLUTIK SUSP	-	NC	NEUROMUSCULAR AGENTS
timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate ophth soln (TIMOPTIC equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	G	BETA BLOCKERS
tinidazole tab (TINDAMAX equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
tiopronin tab (THIOLA equiv)	LMSP-PA	G	GENITOURINARY AGENTS - MISCELLANEOUS
tiotropium bromide cap inhaler (SPIRIVA equiv)	-	NC	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
TIROSINT CAP	-	NC	THYROID AGENTS
TIROSINT-SOL	-	NC	THYROID AGENTS
TIVICAY PD TAB	-	B	ANTIVIRALS
TIVICAY TAB	-	B	ANTIVIRALS
TIVORBEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
tizanidine cap (ZANAFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
TIZANIDINE COMFORT KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER (Only available through Walgreens 888-347-3416)	LD-PA	B	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	B	OPHTHALMIC AGENTS
TOBRADEX ST OPHTH SUSP	-	B	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	G	AMINOGLYCOSIDES
tobramycin neb soln (BETHKIS equiv)	LMSP-RS	NC	AMINOGLYCOSIDES
tobramycin ophth soln (TOBEX equiv)	-	G	OPHTHALMIC AGENTS
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	G	OPHTHALMIC AGENTS
TOBEX OPHTH OINT	-	B	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	\$0	VAGINAL PRODUCTS
TOLAZAMIDE TAB	-	G	ANTIDIABETICS
TOLBUTAMIDE TAB	-	B	ANTIDIABETICS
tolcapone tab (TASMAR equiv)	-	G	ANTIPARKINSON AGENTS
tolmetin cap (TOLECTIN DS equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN TAB	-	B	ANALGESICS - ANTI-INFLAMMATORY
TOLSURA CAP	-	NC	ANTIFUNGALS
tolterodine SR cap (DETROL LA equiv)	-	G	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	G	URINARY ANTISPASMODICS
TOLVAPTAN TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
tolvaptan tab (SAMSCA equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TOPICORT CREAM	-	NC	DERMATOLOGICALS
TOPICORT CREAM 0.05%	-	NC	DERMATOLOGICALS
TOPICORT GEL	-	NC	DERMATOLOGICALS
TOPICORT OINT	-	NC	DERMATOLOGICALS
TOPICORT OINT 0.05%	-	NC	DERMATOLOGICALS
topiramate ER cap (QUDEXY equiv)	-	NC	ANTICONVULSANTS
topiramate er cap (TROKENDI XR equiv)	-	NC	ANTICONVULSANTS
topiramate sprinkle cap (TOPAMAX equiv)	-	G	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	G	ANTICONVULSANTS
toremifene tab (FARESTON equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TORISEL INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
torseamide tab (DEMADEX equiv)	-	G	DIURETICS
TOSYMRA SOLN	-	NC	MIGRAINE PRODUCTS
TOUJEO MAX SOLOSTAR INJ	-	B	ANTIDIABETICS
TOUJEO SOLOSTAR INJ	-	B	ANTIDIABETICS
TOVET KIT	-	NC	DERMATOLOGICALS
TOVIAZ TAB	-	NC	URINARY ANTISPASMODICS
TRACLEER TAB 32MG (QL= 4 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TRADJENTA TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS
TRAMADOL COMPOUND KIT	-	NC	DERMATOLOGICALS
TRAMADOL ER CAP	-	NC	ANALGESICS - OPIOID
tramadol ER tab (ULTRAM ER equiv)	-	G	ANALGESICS - OPIOID
TRAMADOL HCL ER TAB	-	G	ANALGESICS - OPIOID
TRAMADOL HCL TAB	-	NC	ANALGESICS - OPIOID
tramadol hcl tab 100mg	-	NC	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	G	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv)	-	G	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
trandolapril tab (MAVIK equiv)	-	G	ANTIHYPERTENSIVES
TRANDOLAPRIL/VERAPAMIL ER TAB	-	NC	ANTIHYPERTENSIVES
tranexamic acid tab (LYSTEDA equiv)	-	G	HEMOSTATICS
tranylcypromine tab (PARNATE equiv)	-	G	ANTIDEPRESSANTS
travoprost ophth soln (TRAVATAN Z equiv) (QL= 5ml/30 days; Step Therapy requires trial of latanoprost)	QL-ST	G	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	G	ANTIDEPRESSANTS
trazodone tab 300mg (DESYREL equiv)	-	NC	ANTIDEPRESSANTS
TREANDA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TRECATOR TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
TRELEGY ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TREMFYA INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B	DERMATOLOGICALS
treprostinil inj 10mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
treprostinil inj 1mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
treprostinil inj 2.5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
treprostinil inj 5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
TRESIBA FLEXTOUCH INJ	-	B	ANTIDIABETICS
TRESIBA INJ	-	B	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	LMSP	G	ANTINEOPLASTICS
tretinoin cream (QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G	DERMATOLOGICALS
tretinoin gel (QL= 20gm/fill)	PA-QL	G	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv) (QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G	DERMATOLOGICALS
tretinoin gel 0.05% (ATRALIN equiv)	-	NC	DERMATOLOGICALS
tretinoin gel pump 0.04% (TRETINOIN GEL PUMP 0.04% equiv)	-	NC	DERMATOLOGICALS
tretinoin gel pump 0.1% (TRETINOIN GEL PUMP 0.1% equiv)	-	NC	DERMATOLOGICALS
TRETIN-X CREAM	-	NC	DERMATOLOGICALS
TREXALL TAB	-	NC	ANTINEOPLASTICS
TREXIMET TAB	-	NC	MIGRAINE PRODUCTS
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC	ANALGESICS - OPIOID
triamcinolone acetonide inj (KENALOG equiv)	-	G	CORTICOSTEROIDS
triamcinolone acetonide oint (TRIANEX equiv)	-	NC	DERMATOLOGICALS
triamcinolone cream	-	G	DERMATOLOGICALS
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
triamcinolone lotion	-	G	DERMATOLOGICALS
triamcinolone oint	-	G	DERMATOLOGICALS
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamcinolone spray (KENALOG equiv)	-	NC	DERMATOLOGICALS
triamterene cap (DYRENIUM equiv)	-	NC	DIURETICS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	G	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	G	DIURETICS
TRIANEX OINT	-	NC	DERMATOLOGICALS
triazolam tab (HALCION equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
TRIBENZOR TAB	-	NC	ANTIHYPERTENSIVES
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC	DIAGNOSTIC PRODUCTS
TRICHOPHYTON MENTAGROPHYTES SOLN	-	NC	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
TRICHOSOL SOLN	-	NC	PHARMACEUTICAL ADJUVANTS
tricitrates soln (POLYCITRA-LC equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
tricon cap (TRINSICON equiv)	-	G	HEMATOPOIETIC AGENTS
trientine cap (SYPRINE equiv)	LMSP-PA	G	MISCELLANEOUS THERAPEUTIC CLASSE
TRIENTINE CAP	LMSP-PA	NC	MISCELLANEOUS THERAPEUTIC CLASSE
trifluoperazine tab (STELAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
TRIFLURIDINE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
TRIGLIDE TAB	-	NC	ANTIHYPERLIPIDEMICS
trihexyphenidyl elixir (ARTANE equiv)	-	G	ANTIPARKINSON AND RELATED THERAPY AGENTS
TRIHEXYPHENIDYL SOLN	-	G	ANTIPARKINSON AND RELATED THERAPY AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	G	ANTIPARKINSON AGENTS
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	B	ANTIDIABETICS
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
tri-legest tab (ESTROSTEP FE equiv)	-	\$0	CONTRACEPTIVES
TRILIPIX CAP	-	NC	ANTIHYPERLIPIDEMICS
TRILOCICLO KIT	-	NC	DERMATOLOGICALS
TRI-LUMA CREAM	-	EXC	DERMATOLOGICALS
trimethobenzamide cap (TIGAN equiv)	-	G	ANTIEMETICS
TRIMETHOPRIM TAB	-	G	ANTI-INFECTIVE AGENTS - MISC.
trimethoprim tab (PROLOPRIM equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
trimipramine cap (SURMONTIL equiv)	-	G	ANTIDEPRESSANTS
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL-¢	B	ANTIDEPRESSANTS
TRIONEX PACK	-	NC	DERMATOLOGICALS
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0	CONTRACEPTIVES
TRIUMEQ PD TAB	-	B	ANTIVIRALS
TRIUMEQ TAB	-	B	ANTIVIRALS
TRIVISC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
TRIZIVIR TAB	-	B	ANTIVIRALS
TROKENDI XR CAP	-	NC	ANTICONVULSANTS
tropicamide ophth soln (MYDRIACYL equiv)	-	G	OPHTHALMIC AGENTS
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
tropium chloride SR cap (SANCTURA XR equiv)	-	G	URINARY ANTISPASMODICS
tropium tab (SANCTURA equiv)	-	G	URINARY ANTISPASMODICS
TRUDHESA NASAL SPRAY	-	NC	MIGRAINE PRODUCTS
TRULANCE TAB (QL= 1 tab/day)	PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
TRUMENBA INJ	VAC	\$0	VACCINES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
TRUQAP TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TUDORZA PRESSAIR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TUKYSA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TUSSICAPS	-	NC	COUGH/COLD/ALLERGY
tussigon tab (HYCODAN equiv)	-	G	COUGH/COLD/ALLERGY
TUXARIN ER TAB	-	NC	COUGH/COLD/ALLERGY
TUZISTRA XR SUSP	-	NC	COUGH/COLD/ALLERGY
TWINRIX INJ	VAC	\$0	VACCINES
TWIRLA PATCH	-	NC	CONTRACEPTIVES
TWYNEO CREAM	-	NC	DERMATOLOGICALS
TYBLUME TAB	-	\$0	CONTRACEPTIVES
TYBOST TAB	-	NC	ANTIVIRALS
TYKERB TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYMLOS INJ	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYRVAYA SOLN	-	NC	OPHTHALMIC AGENTS
TYSABRI INJ	MSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/2 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS
UCERIS RECTAL FOAM	-	B	ANORECTAL AND RELATED PRODUCTS
UDENYCA INJ	-	NC	HEMATOPOIETIC AGENTS
ULORIC TAB	-	NC	GOUT AGENTS
ULTRAVATE LOTION	-	NC	DERMATOLOGICALS
ULTRAVATE PAC KIT	-	NC	DERMATOLOGICALS
UMECTA EMULSION	-	NC	DERMATOLOGICALS
UMECTA PD EMULSION	-	NC	DERMATOLOGICALS
UMECTA SUSP	-	NC	DERMATOLOGICALS
UPNEEQ SOLN	-	EXC	OPHTHALMIC AGENTS
UPTRAVI INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
URAMAXIN CREAM	-	NC	DERMATOLOGICALS
URAMAXIN GEL	-	NC	DERMATOLOGICALS
urea cream	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
UREA EMULSION	-	NC	DERMATOLOGICALS
urea gel (URAMAXIN equiv)	-	NC	DERMATOLOGICALS
urea lotion (KERALAC LOTION equiv)	-	NC	DERMATOLOGICALS
UREA NAIL KIT	-	NC	DERMATOLOGICALS
UREA SUSP	-	NC	DERMATOLOGICALS
urea susp 40% (UMECTA equiv)	-	NC	DERMATOLOGICALS
UREA/SALICYLIC CREAM	-	NC	DERMATOLOGICALS
ursodiol cap (ACTIGALL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
URSODIOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
UTA cap	-	NC	ANTI-INFECTIVE AGENTS - MISC.
UTIBRON NEOHALER CAP	-	NC	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
valacyclovir tab (VALTREX equiv)	-	G	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Optum Pharmacy 877-445-6874)	LD-PA-QL	B	DERMATOLOGICALS
valganciclovir soln (VALCYTE equiv)	-	G	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	G	ANTIVIRALS
valproate inj (DEPACON equiv)	-	NC	ANTICONSULSANTS
valproic acid cap (DEPAKENE equiv)	-	G	ANTICONSULSANTS
valproic acid syrup (DEPAKENE equiv)	-	G	ANTICONSULSANTS
VALSARTAN SOLN	-	NC	ANTIHYPERTENSIVES
valsartan tab (DIOVAN equiv)	-	G	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	G	ANTIHYPERTENSIVES
VALTOCO NASAL SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B	ANTICONSULSANTS
vancomycin cap (VANCOGIN equiv) (QL= 56 caps/fill)	QL	G	ANTI-INFECTIVE AGENTS - MISC.
vancomycin hcl soln (VANCOMYCIN equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN ORAL SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANFLYTA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VANIQA CREAM	-	EXC	DERMATOLOGICALS
VANOS CREAM	-	NC	DERMATOLOGICALS
vardenafil ODT (STAXYN equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
vardenafil tab (LEVITRA equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab (VARENICLINE equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VARIVAX INJ	VAC	\$0	VACCINES
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	B	ANTIEMETICS
VASCEPA CAP (QL= 4 caps/day)	PA-QL	G	ANTIHYPERLIPIDEMICS
vasoex oint (XENADERM equiv)	-	NC	DERMATOLOGICALS
VAXELIS INJ	VAC	\$0	TOXOIDS
VAXNEUVANCE INJ	VAC	\$0	VACCINES
v-c forte cap (V-C FORTE equiv)	-	G	MULTIVITAMINS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
VECAMYL TAB	-	NC	ANTIHYPERTENSIVES
VECTICAL OINT	-	NC	DERMATOLOGICALS
VELIVET PAK	-	\$0	CONTRACEPTIVES
velivet tab (CYCLESSA equiv)	-	\$0	CONTRACEPTIVES
VELPHORO CHEW TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VELSIPITY TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VELTASSA POWDER	PA	B	ASSORTED CLASSES
VEMLIDY TAB	PA	B	ANTIVIRALS
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
venlafaxine ER cap (EFFEXOR XR equiv)	-	G	ANTIDEPRESSANTS
venlafaxine ER tab	-	NC	ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv)	-	G	ANTIDEPRESSANTS
VENLAFAXINE TAB	-	NC	ANTIDEPRESSANTS
VENNGEL ONE KIT	-	NC	DERMATOLOGICALS
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VEOZAH TAB (QL= 1 tab/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
VERAPAMIL CR CAP, VERELAN CAP	-	NC	CALCIUM CHANNEL BLOCKERS
verapamil SR cap (VERELAN equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	G	CALCIUM CHANNEL BLOCKERS
VERDESO FOAM	-	NC	DERMATOLOGICALS
VERDROCET TAB 2.5MG-325MG	-	NC	ANALGESICS - OPIOID
VEREGEN OINT	-	B	DERMATOLOGICALS
VERELAN CAP	-	NC	CALCIUM CHANNEL BLOCKERS
VERELAN PM ER CAP 100MG, 300MG	-	NC	CALCIUM CHANNEL BLOCKERS
VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist)	QL-RS	B	CARDIOVASCULAR AGENTS - MISC.
VERSACLOZ SUSP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VERSAPENN AL GEL ANHYDROU	-	NC	PHARMACEUTICAL ADJUVANTS
VERZENIO TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VESICARE LS SUSP	-	NC	URINARY ANTISPASMODICS
VESICARE TAB	-	NC	URINARY ANTISPASMODICS
VFEND SUSP	-	NC	ANTIFUNGALS
V-GO INJ KIT (QL= 1 kit/day)	QL	B	MEDICAL DEVICES AND SUPPLIES
VIBERZI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VIBRAMYCIN SYRUP	-	B	TETRACYCLINES
VICTOZA INJ (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
VIDEX SOLN	-	B	ANTIVIRALS
VIEKIRA XR TAB	-	NC	ANTIVIRALS
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0	CONTRACEPTIVES
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G	ANTICONVULSANTS
vigadrone powder pack (Only available through PantheRx 855-726-8479)	LD-PA	G	ANTICONVULSANTS
VIGAMOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
VIIBRYD STARTER KIT	-	NC	ANTIDEPRESSANTS
VIIBRYD TAB	-	NC	ANTIDEPRESSANTS
VIJOICE TAB (QL= 1 tab/day)	MSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSE
VIJOICE TAB 250MG (QL= 2 tabs/day)	MSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSE
vilazodone hcl tab (VIIBRYD equiv)	-	NC	ANTIDEPRESSANTS
VIMOVO TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIMPAT SOLN	-	NC	ANTICONVULSANTS
VIMPAT TAB	-	NC	ANTICONVULSANTS
VINATE II	-	G	MULTIVITAMINS
VINATE M	-	G	MULTIVITAMINS
viorele tab, kariva tab (MIRCETTE equiv)	-	\$0	CONTRACEPTIVES
VIRACEPT TAB	-	B	ANTIVIRALS
VIRAMUNE XR TAB	-	NC	ANTIVIRALS
VIREAD TAB	-	B	ANTIVIRALS
VISCO-3 INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
VISTOGARD PAK	-	NC	ANTIDOTES
VITAFOL GUMMIES	-	NC	MULTIVITAMINS
VITAFOL OB	-	NC	MULTIVITAMINS
VITAFOL STRIPS	-	B	MULTIVITAMINS
VITAFOL ULTRA	-	NC	MULTIVITAMINS
VITAFOL-OB + DHA	-	NC	MULTIVITAMINS
VITAFOL-ONE, VITAFOL FE+	-	NC	MULTIVITAMINS
vitamin D cap (RX strength only)	-	G	VITAMINS
vitamin D cap 1000unit	OTC	NC	VITAMINS
vitamin D cap 400unit	OTC	NC	VITAMINS
VITAMIN D TAB 2000IU	OTC	NC	VITAMINS
VITAMIN D TAB 400UNIT	OTC	NC	VITAMINS
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRECYL IRON TAB	-	NC	MULTIVITAMINS
VITRECYL TAB	-	NC	MULTIVITAMINS
VIVELLE-DOT PATCH	-	NC	ESTROGENS
VIVITROL INJ	LMSP	B	ANTIDOTES
VIVJOA CAP	-	NC	ANTIFUNGALS
VIVLODEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIZIMPRO TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VOCABRIA TAB	-	NC	ANTIVIRALS
VOGELXO PUMP	-	NC	ANDROGENS-ANABOLIC
VOLTAREN GEL	OTC	EXC	DERMATOLOGICALS
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
VOPAC 5 CREAM	-	B	DERMATOLOGICALS
VOPAC CREAM	-	NC	DERMATOLOGICALS
VOPAC GB CREAM	-	NC	DERMATOLOGICALS
VOQUEZNA DUAL PAK	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
VOQUEZNA TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
VOQUEZNA TRIP PAK	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
voriconazole susp (VFEND equiv)	-	G	ANTIFUNGALS
voriconazole tab (VFEND equiv)	-	G	ANTIFUNGALS
VOSEVI TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANTIVIRALS
VOTRIENT TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
VP-PNV-DHA CAP	-	G	MULTIVITAMINS
VPRIV INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
VRAYLAR CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VRAYLAR PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VSL #3 CAP	-	NC	ANTIDIARRHEALS
VTAMA CREAM	-	NC	DERMATOLOGICALS
VTOL SOLN	-	NC	ANALGESICS - NONNARCOTIC
VUITY OPTH SOLN	-	NC	OPHTHALMIC AGENTS
VUMERITY CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYLEESI INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYNDAMAX CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VYTONER CREAM 1.9-1%	-	NC	DERMATOLOGICALS
VYVANSE CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
VYVANSE CHEW TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
VYZULTA SOLN	-	NC	OPHTHALMIC AGENTS
WAINUA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
WAKIX TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
warfarin tab (COUMADIN equiv)	-	G	ANTICOAGULANTS
WEGOVY INJ	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
WEGOVY INJ 1.7MG/0.75ML	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
WEGOVY INJ 2.4MG/0.75ML	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
WELCHOL PACK	-	NC	ANTIHYPERLIPIDEMICS
WELCHOL TAB	-	NC	ANTIHYPERLIPIDEMICS
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
WELLBUTRIN SR TAB	-	NC	ANTIDEPRESSANTS
WELLBUTRIN XL TAB	-	NC	ANTIDEPRESSANTS
WESTCORT OINT	-	NC	DERMATOLOGICALS
WINLEVI CREAM	-	NC	DERMATOLOGICALS
WOUND-DRESSING GELS	-	NC	DERMATOLOGICALS
WPR PLUS	-	NC	DERMATOLOGICALS
WYNZORA CREAM	-	NC	DERMATOLOGICALS
XACIATO GEL (QL= 1 applicator/fill)	QL	B	VAGINAL AND RELATED PRODUCTS
XADAGO TAB (QL= 1 tab/day)	PA-QL	B	ANTIPARKINSON AGENTS
XALIX SOL	-	NC	DERMATOLOGICALS
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XALKORI SPRINKLE CAP (QL= 4 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XAQUIL XR TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
XARELTO STARTER PACK	-	B	ANTICOAGULANTS
XARELTO SUSP	-	B	ANTICOAGULANTS
XARELTO TAB	-	B	ANTICOAGULANTS
XARTEMIS XR TAB	-	NC	ANALGESICS - OPIOID
XCOPRI PAK 100-150MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI PAK 50-200MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI TAB 50MG, 100MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XDEMVY DROP	-	NC	OPHTHALMIC AGENTS
XELJANZ SOLN (QL= 10ml/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
XELPROS OPTH EMULSION	-	NC	OPHTHALMIC AGENTS
XELSTRYM PAD	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	PASSIVE IMMUNIZING AND TREATMENT AGENTS
XENADERM OINT	-	NC	DERMATOLOGICALS
XENAZINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XENICAL CAP	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTI-INFECTIVE AGENTS - MISC.
XEOMIN INJ	MSP-PA	B	NEUROMUSCULAR AGENTS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF Infertility	LD Limited Distribution
PA	Plan Exclusion	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL Quantity Limit	RDX Restricted to Diagnosis
ST	Prior Authorization	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
	Restricted to Specialist	VAC Vaccine Program	¢ RxCENTS
	Step Therapy		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
XEPI CREAM	-	NC	DERMATOLOGICALS
XERESE CREAM	-	NC	DERMATOLOGICALS
XERMELO TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
XGEVA INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
XHANCE NASAL EXHALER	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
XIAFLEX INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B	ASSORTED CLASSES
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	PA-QL	B	ANTI-INFECTIVE AGENTS - MISC.
XIFAXAN TAB 550MG (QL= 2 tabs/day)	PA-QL	B	ANTI-INFECTIVE AGENTS - MISC.
XIGDUO XR TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
XIGDUO XR TAB 10-1000MG (QL= 1 tab/day)	QL	B	ANTIDIABETICS
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	B	ANTIDIABETICS
XIIDRA OPTH SOLN	-	NC	OPHTHALMIC AGENTS
XODOL TAB 10MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 5MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 7.5MG-300MG	-	NC	ANALGESICS - OPIOID
XOFLUZA TAB	-	NC	ANTIVIRALS
XOFLUZA TAB THERAPY PACK 40MG	-	NC	ANTIVIRALS
XOFLUZA TAB THERAPY PACK 80MG	-	NC	ANTIVIRALS
XOLAIR INJ	LMSP-PA	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ	LMSP-PA	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLEGEL	-	NC	DERMATOLOGICALS
XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XPHOZAH TAB (QL= 2 tabs/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
XPROVIO PAK (QL= 32 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XRYLIX PAK	-	NC	DERMATOLOGICALS
XTAMPZA ER CAP (QL= 120 caps/30 days)	QL	B	ANALGESICS - OPIOID
XTANDI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTANDI TAB 40MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTANDI TAB 80MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XULTOPHY INJ (QL= 15ml/30 days)	QL	B	ANTIDIABETICS
XURIDEN POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
XYNTHA INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
XYOSTED INJ	-	NC	ANDROGENS-ANABOLIC
XYREM SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
XYWAV SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYZAL SOLN	-	EXC	ANTIHISTAMINES
XYZAL TAB	-	EXC	ANTIHISTAMINES
XYZBAC TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
YAZ TAB, YASMIN 28 TAB	-	NC	CONTRACEPTIVES
YBUPHEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YONSA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
YOSPRALA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
YUFLYMA INJ KIT (adalimumab-aaty)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YUFLYMA KIT (adalimumab-aaty)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YUPELRI SOLN	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
YUSIMRY INJ (adalimumab-aqvh)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZADITOR OPHTH SOLN	OTC	NC	OPHTHALMIC AGENTS
zafemy patch (XULANE equiv)	-	\$0	CONTRACEPTIVES
zafirlukast tab (ACCOLATE equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
ZANTAC EFFER TAB	-	NC	ULCER DRUGS
ZARXIO INJ	LMSP	B	HEMATOPOIETIC AGENTS
ZAVESCA CAP	-	NC	HEMATOPOIETIC AGENTS
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	B	MIGRAINE PRODUCTS
ZECUITY PAD	-	NC	MIGRAINE PRODUCTS
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
ZEGERID CAP OTC	OTC	EXC	ULCER DRUGS
ZEGERID POWDER PACK	-	NC	ULCER DRUGS
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELAPAR ODT	-	NC	ANTIPARKINSON AGENTS
ZELBORAF TAB (QL= 8 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELNORM TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
zenzedi tab 10mg (DEXEDRINE equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ZEPATIER TAB	-	NC	ANTIVIRALS
ZEPBOUND INJ	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
ZEPOSIA CAP (QL= 1 cap/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZEPOSIA STARTER PACK (QL= 1 cap/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZERVIAE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ZETIA TAB	-	NC	ANTIHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ZETONNA NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
zidovudine cap (RETROVIR equiv)	-	G	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	G	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	G	ANTIVIRALS
ZIEXTENZO INJ	-	NC	HEMATOPOIETIC AGENTS
ZILACAINE PAK	-	NC	DERMATOLOGICALS
ZILBRYSQ INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
zileuton ER tab (ZYFLO CR equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZILXI FOAM	-	NC	DERMATOLOGICALS
ZIMHI SOLN	-	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
ZINBRYTA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZIOPTAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ziprasidone cap (GEODON equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZIPSOR CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZIRGAN OPHTH GEL	-	B	OPHTHALMIC AGENTS
ZITHROMAX POWDER PACK	-	B	MACROLIDES
ZITUVIO TAB	-	NC	ANTIDIABETICS
ZOCOR TAB 80MG	-	NC	ANTIHYPERTENSIVES
ZOHYDRO ER CAP	-	NC	ANALGESICS - OPIOID
ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
ZOLADEX INJ	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZOLINZA CAP	LMSP-PA-SF	B	ANTINEOPLASTICS
zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	G	MIGRAINE PRODUCTS
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	PA-QL	G	MIGRAINE PRODUCTS
ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B	MIGRAINE PRODUCTS
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	PA-QL	G	MIGRAINE PRODUCTS
ZOLPAK KIT	-	NC	DERMATOLOGICALS
ZOLPIDEM CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
zolpidem ER tab (AMBIEN CR equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	G	HYPNOTICS
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOLPIDEM TARTRATE SL TAB 1.75MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOLPIDEM TARTRATE SL TAB 3.5MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOLPIMIST SPRAY	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B	MIGRAINE PRODUCTS
ZOMIG TAB	-	NC	MIGRAINE PRODUCTS

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF Infertility	LD Limited Distribution
PA	Plan Exclusion	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL Quantity Limit	RDX Restricted to Diagnosis
ST	Prior Authorization	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
	Restricted to Specialist	VAC Vaccine Program	¢ RxCENTS
	Step Therapy		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Alphabetical Index
Last Updated 3/1/2024

Drug Name	Special Code	Tier	Category
ZONATUSS CAP 150MG	-	NC	COUGH/COLD/ALLERGY
ZONISADE SUSP (PA required for members age 9 years or older)	PA	B	ANTICONVULSANTS
zonisamide cap (ZONEGRAN equiv)	-	G	ANTICONVULSANTS
ZONIVITY TAB (Restricted to Cardiology Specialist)	RS	B	HEMATOLOGICAL AGENTS - MISC.
ZORVOLEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	B	DERMATOLOGICALS
ZORYVE FOAM	-	NC	DERMATOLOGICALS
ZOVIRAX CREAM	-	NC	DERMATOLOGICALS
ZOVIRAX OINT	-	NC	DERMATOLOGICALS
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B	ANTICONVULSANTS
ZUBSOLV SL TAB	-	NC	ANALGESICS - OPIOID
ZUPLENZ SL FILM	-	NC	ANTIEMETICS
ZURAMPIC TAB	-	NC	GOUT AGENTS
ZURZUVAE CAP	-	NC	ANTIDEPRESSANTS
ZYCLARA CREAM	-	NC	DERMATOLOGICALS
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYFLO TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYKADIA CAP (QL= 3 caps/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYKADIA TAB (QL= 3 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	B	OPHTHALMIC AGENTS
ZYLOTROL-L KIT	-	NC	DERMATOLOGICALS
ZYPITAMAG TAB	-	NC	ANTIHYPERTENSIVES
ZYRTEC CHILD CHEW ALLERGY	OTC	NC	ANTIHISTAMINES
ZYRTEC CHILD CHEW TAB	OTC	EXC	ANTIHISTAMINES

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
ANTI-OBESITY AGENTS		
IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
WEGOVY INJ	-	EXC
WEGOVY INJ 1.7MG/0.75ML	-	EXC
WEGOVY INJ 2.4MG/0.75ML	-	EXC
XENICAL CAP	-	EXC
ZEPBOUND INJ	-	EXC
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine cap (STRATTERA equiv)	-	G
clonidine ER tab (KAPVAY equiv)	-	G
guanfacine ER tab (INTUNIV equiv)	-	G
KAPVAY TAB	-	NC
QELBREE ER CAP	-	NC
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB (QL= 1 tab/day)	PA-QL	B
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
STIMULANTS - MISC.		
METHYLPHENIDATE ER TAB	-	B
armodafanil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	G
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	G
dexmethylphenidate tab (FOCALIN equiv)	-	G
methylphenidate CD cap (METADATE CD equiv)	-	G
methylphenidate chew tab (METHYLIN equiv)	-	G
methylphenidate ER cap (RITALIN LA equiv)	-	G
methylphenidate ER tab	-	G
methylphenidate soln (METHYLIN equiv)	-	G
methylphenidate tab (RITALIN equiv)	-	G
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	G
APTENSIO XR CAP	-	NC
AZSTARYS CAP	-	NC
COTEMPLA XR ODT	-	NC
FOCALIN XR CAP	-	NC
methylphenidate ER cap (APTENSIO XR equiv)	-	NC
methylphenidate td patch (DAYTRANA equiv)	-	NC
NUVIGIL TAB	-	NC
PROVIGIL TAB	-	NC
QUILLICHEW ER TAB	-	NC
QUILLIVANT XR SUSP	-	NC
RELEXXI ER TAB	-	NC
ALLERGENIC EXTRACTS/BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	B
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	B
ODACTRA SL TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer	INF	Inferility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ALLERGENIC EXTRACTS/BIOLOGICALS MISC Cont.		
TRICHOPHYTON MENTAGROPHYTES SOLN	-	NC

ALTERNATIVE MEDICINES

ALTERNATIVE MEDICINE - R'S		
RESERVAPAK SYRUP	-	NC

AMEBICIDES

AMEBICIDES		
SOLOSEC GRANULES PACKET	-	NC

AMINOGLYCOSIDES

AMINOGLYCOSIDES		
ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046)	LD-PA-QL	B
TOBI PODHALER (Only available through Walgreens 888-347-3416)	LD-PA	B
neomycin tab	-	G
paromomycin cap (HUMATIN equiv)	-	G
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	G
HUMATIN CAP	-	NC
KITABIS PAK NEB SOLN	-	NC
tobramycin neb soln (BETHKIS equiv)	-	NC

ANALGESICS - ANTI-INFLAMMATORY

ANTIRHEUMATIC - ENZYME INHIBITORS		
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	B
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	B
XELJANZ SOLN (QL= 10ml/day)	LMSP-PA-QL	B
XELJANZ TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
XELJANZ XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B

ANTIRHEUMATIC ANTIMETABOLITES		
RHEUMATREX TAB	-	B
REDITREX INJ	-	NC

ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-ADAZ PFS INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
HADLIMA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
HADLIMA PUSH INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B
HUMIRA INJ 80MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B
HUMIRA INJ PEDIATRIC UC STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.
** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	LMSP-PA-QL	B
SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B
SIMPONI INJ 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B
ABRILADA INJ	-	NC
AMJEVITA AUTO-INJECTOR (adalimumab-atto)	-	NC
AMJEVITA INJ (adalimumab-atto)	-	NC
CYLTEZO AUTO-INJECTOR (adalimumab-adbm)	-	NC
CYLTEZO INJ (adalimumab-adbm)	-	NC
HULIO INJ (adalimumab fkjp)	-	NC
HULIO KIT (adalimumab-fkjp)	-	NC
HYRIMOZ INJ (adalimumab-adaz)	-	NC
HYRMIOZ PFS INJ (adalimumab-adaz)	-	NC
IDACIO INJ (adalimumab-aacf)	-	NC
SIMPONI ARIA INJ	-	NC
SIMPONI AUTO-INJECTOR 50MG	-	NC
SIMPONI INJ 50MG	-	NC
YUFLYMA INJ KIT (adalimumab-aaty)	-	NC
YUFLYMA KIT (adalimumab-aaty)	-	NC
YUSIMRY INJ (adalimumab-aqvh)	-	NC
GOLD COMPOUNDS		
RIDAURA CAP	-	B
INTERLEUKIN-1 BLOCKERS		
ARCALYST INJ	-	NC
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
ACTEMRA IV INJ	MSP-PA	B
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
KETOPROFEN ER CAP	-	B
SPRIX NASAL SPRAY	PA	B
TOLMETIN TAB	-	B
celecoxib cap (CELEBREX equiv)	-	G
diclofenac potassium tab (CATAFLAM equiv)	-	G
diclofenac sodium EC tab (VOLTAREN equiv)	-	G
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	G
etodolac cap (LODINE equiv)	-	G
etodolac ER tab (LODINE XL equiv)	-	G
etodolac tab	-	G
FLURBIPROFEN TAB	-	G
flurbiprofen tab (ANSAID equiv)	-	G
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	G
ibuprofen tab	-	G
ibuprofen tab ((RX only))	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
indomethacin cap (INDOCIN equiv)	-	G
indomethacin CR cap (INDOCIN SR equiv)	-	G
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	G
MECLOFENAMATE CAP (Step Therapy requires trial of two: diclofenac potassium tab, ketoprofen cap, ibuprofen, or naproxen)	ST	G
meloxicam tab (MOBIC equiv)	-	G
nabumetone tab (RELAFEN equiv)	-	G
naproxen tab (NAPROSYN equiv)	-	G
oxaprozin tab (DAYPRO equiv)	-	G
piroxicam cap (FELDENE equiv)	-	G
sulindac tab (CLINORIL equiv)	-	G
tolmetin cap (TOLECTIN DS equiv)	-	G
ANAPROX TAB	-	NC
ARTHROTEC TAB	-	NC
CELEBREX CAP	-	NC
COXANTO CAP	-	NC
DICLOFENAC CAP	-	NC
diclofenac potassium cap (ZIPSOR equiv)	-	NC
diclofenac potassium tab 25mg (DICLOFENAC equiv)	-	NC
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC
fenoprofen calcium cap (NALFON equiv)	-	NC
fenoprofen calcium tab	-	NC
FENOPROFEN CAP	-	NC
FENOPROFEN TAB	-	NC
IBU 600-EZS KIT	-	NC
ibuprofen-famotidine tab (DUEXIS equiv)	-	NC
INDOCIN SUPP	-	NC
INDOCIN SUSP	-	NC
INDOMETHACIN CAP, TIVORBEX CAP	-	NC
indomethacin suppository (INDOCIN equiv)	-	NC
indomethacin susp (INDOCIN equiv)	-	NC
INFLATHERM PAK	-	NC
KETOPROFEN CAP	-	NC
ketoprofen cap (ORUDIS equiv)	-	NC
KETOROLAC INJ	-	NC
ketorolac inj (TORADOL equiv)	-	NC
mefenamic acid cap (PONSTEL equiv)	-	NC
meloxicam cap (VIVLODEX equiv)	-	NC
MELOXICAM COMFORT KIT	-	NC
MELOXICAM SUSP	-	NC
NAFLON CAP	-	NC
NAPRELAN CR TAB	-	NC
NAPROSYN EC TAB	-	NC
NAPROSYN EC TAB 500MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
naproxen EC tab (NAPROSYN EC equiv)	-	NC
naproxen EC tab 500mg (NAPROSYN EC equiv)	-	NC
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC
naproxen sodium tab (ANAPROX equiv)	-	NC
NAPROXEN SUSP	-	NC
naproxen susp (NAPROSYN equiv)	-	NC
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	NC
QMIIZ ODT TAB	-	NC
RELAFEN DS TAB	-	NC
TIVORBEX CAP	-	NC
TOLMETIN CAP	-	NC
VIMOVO TAB	-	NC
VIVLODEX CAP	-	NC
YBUPHEN TAB	-	NC
ZIPSOR CAP	-	NC
ZORVOLEX CAP	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	G
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	B
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	B
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	B
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	B
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
butalbital/acetaminophen tab 50-325mg (PHRENILIN equiv) (QL= 60 tabs/30 days)	PA-QL	G
butalbital/acetaminophen/caffeine tab (FIORICET equiv) (QL= 60 tabs/30 days)	PA-QL	G
butalbital/aspirin/caffeine cap (FIORINAL equiv) (QL= 60 tabs/30 days)	PA-QL	G
ALLZITAL TAB	-	NC
bupap tab	-	NC
butalbital/acetaminophen cap	-	NC
butalbital/acetaminophen/caffeine cap (FIORICET equiv)	-	NC
butalbital/acetaminophen/caffeine soln	-	NC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC
DOLGIC PLUS TAB	-	NC
VTOL SOLN	-	NC
SALICYLATES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANALGESICS - NONNARCOTIC Cont.		
aspirin chew tab 81mg (Covered for females up to 60 years of age)	OTC	\$0
aspirin ec tab 81mg (Covered for females up to 60 years of age)	OTC	\$0
diflunisal tab (DOLOBID equiv)	-	G
salsalate tab (DISALCID equiv)	-	G
aspirin EC tab 325mg	OTC	NC
aspirin tab 325mg	OTC	NC
ANALGESICS - OPIOID		
OPIOID AGONISTS		
ABSTRAL SL TAB (QL= 120 tabs/30 days)	PA-QL	B
CODEINE SULFATE SOLN	-	B
FENTORA TAB, FENTANYL BUCCAL TAB (QL= 120 tabs/30 days)	PA-QL	B
HYDROCODONE BITARTRATE ER CAP (QL= 2 caps/day)	QL	B
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days)	PA-QL	B
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	B
NUCYNTA TAB	-	B
OXYCODONE ER TAB (QL= 2 tabs/day)	QL	B
XTAMPZA ER CAP (QL= 120 caps/30 days)	QL	B
CODEINE SULFATE TAB	-	G
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	G
fentanyl patch (DURAGESIC equiv)	-	G
hydrocodone bitartrate ER cap (ZOHYDRO equiv) (QL= 2 caps/day)	QL	G
hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day)	QL	G
hydromorphone tab (DILAUDID equiv)	-	G
methadone soln	-	G
methadone tab (DOLOPHINE equiv)	-	G
methadose tab	-	G
MORPHINE SULF SOLN 10MG/5ML	-	G
morphine sulfate ER tab (MS CONTIN equiv)	-	G
MORPHINE SULFATE SOLN	-	G
MORPHINE SULFATE SUPP	-	G
MORPHINE SULFATE TAB	-	G
oxycodone cap (OXYIR equiv)	-	G
oxycodone conc (ROXICODONE equiv)	-	G
oxycodone soln (ROXICODONE equiv)	-	G
oxycodone tab (ROXICODONE equiv)	-	G
tramadol ER tab (ULTRAM ER equiv)	-	G
TRAMADOL HCL ER TAB	-	G
tramadol tab (ULTRAM equiv)	-	G
ARYMO ER TAB	-	NC
DSUVIA SL TAB	-	NC
EMBEDA CAP	-	NC
EXALGO TAB	-	NC
fentanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC
hydromorphone ER tab (EXALGO TAB equiv)	-	NC
HYDROMORPHONE SUPP	-	NC
LEVORPHANOL TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
levorphanol tab (LEVORPHANOL equiv)	-	NC
meperidine tab (DEMEROL equiv)	-	NC
MORPHABOND TAB	-	NC
MORPHINE SULFATE ER BEAD CAP	-	NC
MORPHINE SULFATE ER CAP	-	NC
morphine sulfate ER cap (KADIAN equiv)	-	NC
OPANA ER TAB (CRUSH RESISTANT)	-	NC
OPANA TAB	-	NC
OXYCONTIN CR TAB	-	NC
OXYMORPHONE ER TAB	-	NC
oxymorphone tab (OPANA equiv)	-	NC
QDOLO SOLN, TRAMADOL SOLN	-	NC
ROXYBOND TAB	-	NC
RYBIX ODT	-	NC
SUBSYS SPRAY	-	NC
TRAMADOL ER CAP	-	NC
TRAMADOL HCL TAB	-	NC
tramadol hcl tab 100mg	-	NC
ZOHYDRO ER CAP	-	NC
OPIOID COMBINATIONS		
HYDROCODONE/IBUPROFEN TAB 10-200MG	-	B
LORTAB ELIXIR	-	B
acetaminophen/codeine soln	-	G
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	G
APAP/CODEINE SOLN	-	G
aspirin/codeine tab	-	G
hydrocodone/acetaminophen cap (LORCET equiv)	-	G
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	G
hydrocodone/acetaminophen tab (LORTAB equiv)	-	G
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	G
oxycodone/acetaminophen cap (TYLOX equiv)	-	G
OXYCODONE/ACETAMINOPHEN SOLN	-	G
oxycodone/acetaminophen tab (PERCOCET equiv)	-	G
OXYCODONE/ASPIRIN TAB	-	G
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	G
pentazocine/acetaminophen tab (TALACEN equiv)	-	G
tramadol/acetaminophen tab (ULTRACET equiv)	-	G
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC
APADAZ TAB	-	NC
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	NC
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC
OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML	-	NC
OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG	-	NC
PRIMLEV TAB 10-300MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
PRIMLEV TAB 5-300MG	-	NC
PROLATE TAB 7.5-300MG	-	NC
SEGLENTIS TAB	-	NC
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC
VERDROCET TAB 2.5MG-325MG	-	NC
XARTEMIS XR TAB	-	NC
XODOL TAB 10MG-300MG	-	NC
XODOL TAB 5MG-300MG	-	NC
XODOL TAB 7.5MG-300MG	-	NC
OPIOID PARTIAL AGONISTS		
BRIXADI SOLN 128MG/0.36ML (Only available through Walgreens 888-347-3416)	LD	B
BRIXADI SOLN 16MG/0.32ML (Only available through Walgreens 888-347-3416)	LD	B
BRIXADI SOLN 24MG/0.48ML (Only available through Walgreens 888-347-3416)	LD	B
BRIXADI SOLN 32MG/0.64ML (Only available through Walgreens 888-347-3416)	LD	B
BRIXADI SOLN 64MG/0.18ML (Only available through Walgreens 888-347-3416)	LD	B
BRIXADI SOLN 8MG/0.16ML (Only available through Walgreens 888-347-3416)	LD	B
BRIXADI SOLN 96MG/0.27ML (Only available through Walgreens 888-347-3416)	LD	B
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days)	QL	G
buprenorphine SL tab (SUBUTEX equiv)	-	G
buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv)	-	G
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	G
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	G
pentazocine/naloxone tab (TALWIN NX equiv)	-	G
BELBUCA FILM	-	NC
BUNAVAIL FILM	-	NC
buprenorphine hcl buccal film (BELBUCA equiv)	-	NC
SUBLOCADE SOLN	-	NC
SUBOXONE SL FILM	-	NC
ZUBSOLV SL TAB	-	NC

ANDROGENS-ANABOLIC

ANDROGENS		
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	B
METHITEST TAB (Step Therapy requires trial of ANDROGEL or ANDRODERM)	ST	B
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	B
danazol cap (DANOCRINE equiv)	-	G
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	G
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	G
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	G
ANDROGEL 1% 25MG	-	NC
ANDROGEL 1% 50MG, TESTIM GEL 1%	-	NC
ANDROGEL 1.62% 1.25GM	-	NC
ANDROGEL 1.62% 2.5GM	-	NC
ANDROGEL PUMP 1%	-	NC
KYZATREX CAP, JATENZO CAP, TLANDO CAP	-	NC
methyltestosterone cap	-	NC
NATESTO GEL	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	generic = small letters	LD	BRANDS = CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	INF	OTC	Over-the-Counter
PA	Prior Authorization	MSP	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	QL	SMKG	Smoking Cessation
ST	Step Therapy	SF	¢	RxCENTS
		VAC		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
NATESTO NASAL GEL	-	NC
STRIANT FILM	-	NC
TESTOSTERONE GEL 1% 25MG	-	NC
testosterone gel 1% 25mg (ANDROGEL equiv)	-	NC
testosterone gel 1% 50mg (ANDROGEL equiv)	-	NC
testosterone gel 1% pump (ANDROGEL equiv)	-	NC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv)	-	NC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv)	-	NC
testosterone gel 2% (FORTESTA equiv)	-	NC
TESTOSTERONE GEL PUMP	-	NC
TESTOSTERONE GEL, VOGELXO GEL	-	NC
VOGELXO PUMP	-	NC
XYOSTED INJ	-	NC
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
CORTIFOAM	-	B
hydrocortisone enema (CORTENEMA equiv)	-	G
RECTAL COMBINATIONS		
ANALPRAM-E KIT	-	B
PROCTOFOAM HC FOAM	-	B
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	G
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	G
LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT	-	NC
RECTAL STEROIDS		
hydrocortisone supp (ANUSOL HC equiv)	-	G
proctosol HC cream (ANUSOL HC equiv)	-	G
anusol-HC supp	-	NC
PROCTOCORT SUPP	-	NC
VASODILATING AGENTS		
RECTIV OINT	-	B
ANORECTAL AND RELATED PRODUCTS		
INTRARECTAL STEROIDS		
budesonide rectal foam (UCERIS RECTAL FOAM equiv)	-	B
UCERIS RECTAL FOAM	-	B
RECTAL COMBINATIONS		
ANALPRAM-HC CREAM	-	B
HYDROCORTISONE ACETATE/PRAMOXINE CREAM	-	G
HYDROCORTISONE/PRAMOXINE SUPP	-	NC
RECTAL LOCAL ANESTHETICS		
LIDOCAINE SUPP	-	NC
ANTHELMINTICS		
ANTHELMINTICS		
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	B
BILTRICIDE TAB	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTHELMINTICS Cont.		
ivermectin tab (STROMEKTOL equiv)	PA	G
praziquantel tab (BILTRICIDE equiv)	-	G
EGATEN TAB	-	NC
EMVERM TAB	-	NC

ANTIANGINAL AGENTS

ANTIANGINALS-OTHER		
ranolazine tab (RANEXA equiv)	-	G
ASPRUZYO SPRINKLE GRANULES	-	NC

NITRATES		
NITRO-BID OINT	-	B
NITROMIST SPRAY	-	B
isosorbide dinitrate SL tab	-	G
isosorbide dinitrate tab (ISORDIL equiv)	-	G
isosorbide dinitrate tab 40mg (ISORDIL equiv)	-	G
isosorbide mononitrate ER tab (IMDUR equiv)	-	G
ISOSORBIDE MONONITRATE TAB	-	G
isosorbide mononitrate tab (MONOKET equiv)	-	G
NITROGLYCERIN ER CAP	-	G
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	G
nitroglycerin patch (NITRO-DUR equiv)	-	G
nitroglycerin SL tab (NITROSTAT equiv)	-	G
GONITRO POWDER	-	NC
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	NC

ANTIANGIETY AGENTS

ANTIANGIETY AGENTS - MISC.		
bupirone tab (BUSPAR equiv)	-	G
hydroxyzine pamoate cap (VISTARIL equiv)	-	G
hydroxyzine syrup (ATARAX equiv)	-	G
hydroxyzine tab (ATARAX equiv)	-	G
bupirone tab 30mg (BUSPAR equiv)	-	NC
meprobamate tab (MILTOWN equiv)	-	NC

BENZODIAZEPINES		
alprazolam ER tab (XANAX XR equiv)	-	G
alprazolam ODT (NIRAVAM equiv)	-	G
alprazolam tab (XANAX equiv)	-	G
chlordiazepoxide cap (LIBRIUM equiv)	-	G
clorazepate tab (TRANXENE-T equiv)	-	G
diazepam conc (VALIUM equiv)	-	G
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	G
diazepam tab (VALIUM equiv)	-	G
lorazepam conc (ATIVAN equiv)	-	G
lorazepam tab (ATIVAN equiv)	-	G
oxazepam cap (SERAX equiv)	-	G
LOREEV XR CAP	-	NC

ANTIARRHYTHMICS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIARRHYTHMICS Cont.		
ANTIARRHYTHMICS TYPE I-A		
NORPACE CR CAP	-	B
disopyramide cap (NORPACE equiv)	-	G
disopyramide ER cap (NORPACE CR equiv)	-	G
quinidine gluconate CR tab	-	G
quinidine sulfate tab	-	G
QUINIDINE SULFATE TAB	-	NC
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap	-	G
ANTIARRHYTHMICS TYPE I-C		
flecainide tab (TAMBOCOR equiv)	-	G
propafenone ER cap (RYTHMOL SR equiv)	-	G
propafenone tab (RYTHMOL equiv)	-	G
ANTIARRHYTHMICS TYPE III		
MULTAQ TAB	-	B
amiodarone tab (CORDARONE equiv)	-	G
dofetilide cap (TIKOSYN equiv)	-	G
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
FASENRA PEN INJ (QL= 1 inj/56 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
TEZSPIRE INJ (QL= 1 pen/28 days)	LMSP-PA-QL	B
XOLAIR INJ	LMSP-PA	B
XOLAIR SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	B
XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
XOLAIR INJ	-	NC
ANTI-INFLAMMATORY AGENTS		
cromolyn neb soln (INTAL equiv)	-	NC
BRONCHODILATORS - ANTICHOLINERGICS		
ATROVENT HFA INHALER	-	B
INCRUSE ELLIPTA INHALER	-	B
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL))	QL-ST	B
ipratropium neb soln (ATROVENT equiv)	-	G
LONHALA MAGNAIR SOLN	-	NC
SEEBRI NEOHALER CAP	-	NC
SPIRIVA HANDIHALER	-	NC
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	-	NC
tiotropium bromide cap inhaler (SPIRIVA equiv)	-	NC
TUDORZA PRESSAIR INHALER	-	NC
YUPELRI SOLN	-	NC
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	G
montelukast granule pack (SINGULAIR equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
montelukast tab (SINGULAIR equiv)	-	G
zafirlukast tab (ACCOLATE equiv)	-	G
zileuton ER tab (ZYFLO CR equiv)	-	NC
ZYFLO TAB	-	NC
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
DALIRESP TAB	-	B
roflumilast tab	PA	G
STEROID INHALANTS		
FLUTICASONE PROPIONATE DISKUS INHALER 100MCG/ACT	-	B
FLUTICASONE PROPIONATE DISKUS INHALER 250MCG/ACT	-	B
FLUTICASONE PROPIONATE DISKUS INHALER 50MCG/ACT	-	B
ARNUITY ELLIPTA INHALER	-	G
ASMANEX HFA INHALER	-	G
ASMANEX INHALER	-	G
budesonide inh susp (PULMICORT equiv)	-	G
FLUTICASONE DISKUS INHALER	-	G
FLUTICASONE HFA INHALER	-	G
ALVESCO INHALER	-	NC
ARMONAIR DIGITAL INHALER 113MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 232MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 55MCG/ACT	-	NC
FLOVENT DISKUS INHALER	-	NC
FLOVENT HFA INHALER	-	NC
PULMICORT FLEXHALER	-	NC
QVAR INHALER	-	NC
QVAR REDIHALER	-	NC
SYMPATHOMIMETICS		
ADVAIR HFA INHALER	-	B
ALBUTEROL TAB ER	-	B
ANORO ELLIPTA INHALER	-	B
BREO ELLIPTA INHALER	-	B
BREO ELLIPTA INHALER 50-25 MCG/ACT	-	B
BREZTRI AEROSPHERE INHALER	-	B
COMBIVENT RESPIMAT INHALER	-	B
DULERA INHALER	-	B
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA)	QL-ST	B
METAPROTERENOL TAB	-	B
SEREVENT DISKUS INHALER	-	B
STIOLTO INHALER	-	B
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	B
TRELEGY ELLIPTA INHALER	-	B
albuterol HFA inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	G
albuterol neb soln	-	G
ALBUTEROL NEBULIZER SOLN	-	G
albuterol sulfate syrup	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
albuterol sulfate tab	-	G
albuterol/ipratropium neb soln (DUONEB equiv)	-	G
arformoterol tartrate neb soln (BROVANA equiv) (Step Therapy requires trial of PERFOROMIST)	ST	G
budesonide/formoterol inhaler (SYMBICORT equiv)	-	G
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	G
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	G
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	G
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	G
formoterol fumarate neb soln (PERFOROMIST equiv)	-	G
levalbuterol neb soln (XOPENEX equiv)	-	G
METAPROTERENOL SYRUP	-	G
terbutaline sulfate tab (BRETHINE equiv)	-	G
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	G
ADVAIR DISKUS INHALER	-	NC
AIRDUO POWDER INHALER W/SENSOR	-	NC
AIRDUO RESPICLICK	-	NC
AIRSUPRA INH	-	NC
ALBUTEROL HFA INHALER	-	NC
BEVESPI AEROSPHERE INHALER	-	NC
DUAKLIR INHALER	-	NC
FLUTICASONE-SALMETEROL INHALER 115-21 MCG/ACT	-	NC
FLUTICASONE-SALMETEROL INHALER 230-21 MCG/ACT	-	NC
FLUTICASONE-SALMETEROL INHALER 45-21 MCG/ACT	-	NC
FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT	-	NC
FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT	-	NC
SYMBICORT INHALER	-	NC
UTIBRON NEOHALER CAP	-	NC
XANTHINES		
ELIXOPHYLLIN ELIXIR	-	B
THEOPHYLLINE TAB ER	-	B
theophylline er tab (THEOPHYLLINE ER equiv)	-	G
theophylline ER tab (UNIPHYL equiv)	-	G
theophylline soln	-	G

ANTICOAGULANTS

COUMARIN ANTICOAGULANTS

warfarin tab (COUMADIN equiv)	-	G
-------------------------------	---	---

DIRECT FACTOR XA INHIBITORS

ELIQUIS TAB, ELIQUIS STARTER PACK	-	B
XARELTO STARTER PACK	-	B
XARELTO SUSP	-	B
XARELTO TAB	-	B
SAVAYSA TAB	-	NC

HEPARINS AND HEPARINOID-LIKE AGENTS

FRAGMIN INJ	-	B
enoxaparin inj (LOVENOX equiv)	-	G
fondaparinux inj (ARIXTRA equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTICOAGULANTS Cont.		
ARIXTRA INJ	-	NC
THROMBIN INHIBITORS		
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	G
PRADAXA PELLETT PACK	-	NC
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA TAB	-	B
FYCOMPA SUSP	-	B
ANTICONVULSANTS - BENZODIAZEPINES		
DIASTAT ACDL GEL (QL= 2 packs/fill)	QL	B
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 2 packs/fill)	QL	B
DIAZEPAM GEL (QL= 2 packs/fill)	QL	B
NAYZILAM SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B
VALTOCO NASAL SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B
clobazam susp (ONFI equiv) (Members age 9 or older require Prior Authorization)	PA	G
clobazam tab (ONFI equiv)	PA	G
clonazepam ODT (KLONOPIN equiv)	-	G
clonazepam tab (KLONOPIN equiv)	-	G
diazepam rectal gel (QL= 2 packs/fill)	QL	G
ONFI SUSP	-	NC
ONFI TAB	-	NC
SYMPAZAN ORAL FILM	-	NC
ANTICONVULSANTS - MISC.		
BANZEL SUSP	PA	B
DIACOMIT CAP (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B
DIACOMIT POWDER PACK (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B
EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553)	LD-PA	B
EPRONTIA SOLN (Members age 9 or older require Prior Authorization)	PA	B
FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	B
POTIGA TAB (QL= 3 tabs/day)	QL	B
ZONISADE SUSP (PA required for members age 9 years or older)	PA	B
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B
carbamazepine chew tab (TEGRETOL equiv)	-	G
carbamazepine ER cap (CARBATROL equiv)	-	G
carbamazepine ER tab (TEGRETOL XR equiv)	-	G
carbamazepine susp (TEGRETOL equiv)	-	G
carbamazepine tab (TEGRETOL equiv)	-	G
gabapentin cap 100mg (NEURONTIN equiv) (QL= 9 caps/day)	QL	G
gabapentin cap 300mg (NEURONTIN equiv) (QL= 6 caps/day)	QL	G
gabapentin cap 400mg (NEURONTIN equiv) (QL= 4 caps/day)	QL	G
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	G
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	G
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	G
lacosamide oral solution (VIMPAT equiv)	-	G
lacosamide tab (VIMPAT equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	OTC	Limited Distribution
PA	Plan Exclusion	MSP	RDX	Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	SMKG	Restricted to Diagnosis
ST	Prior Authorization	SF	¢	Smoking Cessation
	Restricted to Specialist	VAC		RxCENTS
	Step Therapy			

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
lamotrigine chew tab (LAMICTAL equiv)	-	G
lamotrigine ER tab (LAMICTAL XR equiv)	-	G
lamotrigine ODT (LAMICTAL equiv)	-	G
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	G
lamotrigine tab (LAMICTAL equiv)	-	G
levetiracetam ER tab (KEPPRA XR equiv)	-	G
levetiracetam soln (KEPPRA equiv)	-	G
levetiracetam tab (KEPPRA equiv)	-	G
oxcarbazepine susp (TRILEPTAL equiv)	-	G
oxcarbazepine tab (TRILEPTAL equiv)	-	G
pregabalin cap (LYRICA equiv) (QL= 3 caps/day)	QL	G
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	G
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	G
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	G
primidone tab (MYSOLINE equiv)	-	G
rufinamide susp (BANZEL equiv)	PA	G
rufinamide tab (BANZEL equiv)	PA	G
topiramate sprinkle cap (TOPAMAX equiv)	-	G
topiramate tab (TOPAMAX equiv)	-	G
zonisamide cap (ZONEGRAN equiv)	-	G
APTIOM TAB	-	NC
BANZEL TAB	-	NC
BRIVIACT INJ 50MG/5ML	-	NC
BRIVIACT SOLN 10MG/ML	-	NC
BRIVIACT TAB	-	NC
ELEPSIA XR TAB	-	NC
LYRICA CAP	-	NC
LYRICA CAP 225MG	-	NC
LYRICA CAP 300MG	-	NC
MOTPOLY XR CAP	-	NC
NEURONTIN SOLN	-	NC
NEURONTIN TAB 600MG	-	NC
NEURONTIN TAB 800MG	-	NC
OXTELLAR XR TAB	-	NC
PRIMIDONE TAB	-	NC
QUDEXY XR CAP	-	NC
SPRITAM TAB	-	NC
topiramate ER cap (QUDEXY equiv)	-	NC
topiramate er cap (TROKENDI XR equiv)	-	NC
TROKENDI XR CAP	-	NC
VIMPAT SOLN	-	NC
VIMPAT TAB	-	NC
CARBAMATES		
XCOPRI PAK 100-150MG (QL= 2 tabs/day)	QL	B
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	B
XCOPRI PAK 50-200MG (QL= 2 tabs/day)	QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day)	QL	B
XCOPRI TAB 50MG, 100MG (QL= 1 tab/day)	QL	B
XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day)	QL	B
XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day)	QL	B
XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day)	QL	B
felbamate susp (FELBATOL equiv)	-	G
felbamate tab (FELBATOL equiv)	-	G
FELBATOL TAB	-	NC
GABA MODULATORS		
tiagabine tab (GABITRIL equiv)	-	G
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G
vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G
vigadrone powder pack (Only available through PantheRx 855-726-8479)	LD-PA	G
SABRIL TAB	-	NC
HYDANTOINS		
DILANTIN CAP 30MG	-	B
PEGANONE TAB	-	B
phenytoin cap (DILANTIN equiv)	-	G
phenytoin chew tab (DILANTIN equiv)	-	G
phenytoin susp (DILANTIN equiv)	-	G
SUCCINIMIDES		
ethosuximide cap (ZARONTIN equiv)	-	G
ethosuximide soln (ZARONTIN equiv)	-	G
methsuximide cap (CELONTIN equiv)	-	G
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	G
divalproex sodium DR tab (DEPAKOTE equiv)	-	G
divalproex sprinkle cap (DEPAKOTE equiv)	-	G
valproic acid cap (DEPAKENE equiv)	-	G
valproic acid syrup (DEPAKENE equiv)	-	G
DEPACON INJ	-	NC
STAVZOR CAP	-	NC
valproate inj (DEPACON equiv)	-	NC
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	G
mirtazapine tab (REMERON equiv)	-	G
ANTIDEPRESSANT COMBINATIONS		
AUVELITY TAB	-	NC
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	G
bupropion tab (WELLBUTRIN equiv)	-	G
bupropion XL tab (WELLBUTRIN XL equiv)	-	G
MAPROTILINE TAB	-	G
APLENZIN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

ANTIDEPRESSANTS Cont.

FORFIVO XL TAB	-	NC
WELLBUTRIN SR TAB	-	NC
WELLBUTRIN XL TAB	-	NC

GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID

ZURZUVAE CAP	-	NC
--------------	---	----

MONOAMINE OXIDASE INHIBITORS (MAOIS)

EMSAM PATCH	-	B
MARPLAN TAB	-	B
NARDIL TAB 15MG	-	B
PHENELZINE SULFATE TAB	-	G
phenelzine tab (NARDIL equiv)	-	G
tranylcypromine tab (PARNATE equiv)	-	G

N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS

SPRAVATO NASAL SOLN	-	NC
---------------------	---	----

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)

citalopram soln (CELEXA equiv)	-	G
citalopram tab (CELEXA equiv)	-	G
escitalopram soln (LEXAPRO equiv)	-	G
escitalopram tab (LEXAPRO equiv)	-	G
fluoxetine cap (PROZAC equiv)	-	G
fluoxetine soln (PROZAC equiv)	-	G
fluoxetine tab (PROZAC equiv)	-	G
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	G
fluvoxamine tab (LUVOX equiv)	-	G
paroxetine ER tab (PAXIL CR equiv)	-	G
paroxetine oral susp (PAXIL equiv)	-	G
paroxetine tab (PAXIL equiv)	-	G
sertraline conc (ZOLOFT equiv)	-	G
sertraline tab (ZOLOFT equiv)	-	G
CITALOPRAM CAP	-	NC
FLUOXETINE TAB 60MG	-	NC
fluoxetine weekly cap (PROZAC equiv)	-	NC
PEXEVA TAB	-	NC
PROZAC WEEKLY CAP	-	NC
SERTRALINE CAP	-	NC

SEROTONIN MODULATORS

TRINTELLIX TAB (QL= 1 tab/day)	PA-QL-¢	B
NEFAZODONE TAB	-	G
nefazodone tab 50mg, 250mg	-	G
trazodone tab (DESYREL equiv)	-	G
trazodone tab 300mg (DESYREL equiv)	-	NC
VIIBRYD STARTER KIT	-	NC
VIIBRYD TAB	-	NC
vilazodone hcl tab (VIIBRYD equiv)	-	NC

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

ANTIDEPRESSANTS Cont.

desvenlafaxine ER tab (PRISTIQ equiv)	-	G
duloxetine EC cap (CYMBALTA equiv)	-	G
venlafaxine ER cap (EFFEXOR XR equiv)	-	G
venlafaxine tab (EFFEXOR equiv)	-	G
DESVENLAFAXINE ER TAB	-	NC
DRIZALMA DR CAP	-	NC
duloxetine cap 40mg (IRENKA equiv)	-	NC
EFFEXOR XR CAP	-	NC
FETZIMA CAP	-	NC
FETZIMA TITRATION PACK	-	NC
venlafaxine ER tab	-	NC
VENLAFAXINE TAB	-	NC

TRICYCLIC AGENTS

amitriptyline tab (ELAVIL equiv)	-	G
amoxapine tab (AMOXAPINE equiv)	-	G
clomipramine cap (ANAFRANIL equiv)	-	G
desipramine tab (NORPRAMIN equiv)	-	G
doxepin cap (SINEQUAN equiv)	-	G
doxepin conc (SINEQUAN equiv)	-	G
imipramine pamoate cap (TOFRANIL PM equiv)	-	G
imipramine tab (TOFRANIL equiv)	-	G
nortriptyline cap (PAMELOR equiv)	-	G
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	G
protriptyline tab (VIVACTIL equiv)	-	G
trimipramine cap (SURMONTIL equiv)	-	G

ANTIDIABETICS

ALPHA-GLUCOSIDASE INHIBITORS

MIGLITOL TAB	-	B
acarbose tab (PRECOSE equiv)	-	G
miglitol tab (MIGLITOL equiv)	-	G

ANTIDIABETIC - AMYLIN ANALOGS

SYMLINPEN INJ	PA	B
---------------	----	---

ANTIDIABETIC COMBINATIONS

GLYXAMBI TAB (QL= 1 tab/day)	QL	B
JANUMET TAB (QL= 2 tabs/day)	QL	B
JANUMET XR TAB (QL= 2 tabs/day)	QL	B
JENTADUETO TAB (QL= 2 tabs/day)	QL	B
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	B
SOLIQUA INJ (QL= 15ml/25 days)	QL	B
SYNJARDY TAB (QL= 2 tabs/day)	QL	B
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	B
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	B
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	B
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day)	QL	B
XIGDUO XR TAB (QL= 2 tabs/day)	QL	B
XIGDUO XR TAB 10-1000MG (QL= 1 tab/day)	QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	B
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	B
XULTOPHY INJ (QL= 15ml/30 days)	QL	B
glipizide/metformin tab (METAGLIP equiv)	-	G
glyburide/metformin tab (GLUCOVANCE equiv)	-	G
ACTOPLUS MET TAB	-	NC
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC
ALOGLIPTIN-METFORMIN TAB	-	NC
ALOGLIPTIN-PIOGILTAZONE TAB	-	NC
DAPAGLIFLOZIN PROP-METFORMIN HCL 10-1000MG	-	NC
DAPAGLIFLOZIN PROP-METFORMIN HCL 5-1000MG	-	NC
DUETACT TAB	-	NC
INVOKAMET TAB	-	NC
INVOKAMET XR TAB	-	NC
KOMBIGLYZE XR TAB	-	NC
pioglitazone/glimepiride tab (DUETACT equiv)	-	NC
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	NC
PRANDIMET TAB	-	NC
QTERN TAB	-	NC
saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv)	-	NC
SEGLUROMET TAB	-	NC
STEGLUJAN TAB	-	NC
BIGUANIDES		
RIOMET ER SUSP	PA	B
metformin ER tab (GLUCOPHAGE XR equiv)	-	G
metformin soln (RIOMET equiv)	-	G
metformin tab (GLUCOPHAGE equiv)	-	G
FORTAMET TAB	-	NC
GLUMETZA TAB 1000MG	-	NC
GLUMETZA TAB 500MG	-	NC
metformin ER osmotic tab (FORTAMET equiv)	-	NC
metformin ER osmotic tab (GLUMETZA equiv)	-	NC
METFORMIN TAB	-	NC
DIABETIC OTHER		
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	B
GLUCAGEN HYPOKIT INJ (QL= 2 inj/fill)	QL	B
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	B
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	B
GVOKE INJ (QL= 2 inj/fill)	QL	B
GVOKE INJ KIT (QL= 2 inj/fill)	QL	B
GVOKE PFS INJ (QL= 2 inj/fill)	QL	B
mifepristone tab (KORLYM equiv) (QL= 4 tabs/day; Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA-QL	B
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	B
diazoxide susp (PROGLYCEM equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
GLUCAGON KIT (QL= 2 inj/fill)	QL	G
KORLYM TAB	-	NC
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
JANUVIA TAB (QL= 1 tab/day)	QL-¢	B
TRADJENTA TAB (QL= 1 tab/day)	QL	B
ALOGLIPTIN TAB	-	NC
ALOGLIPTIN TAB, NESINA TAB	-	NC
ONGLYZA TAB	-	NC
saxagliptin hcl tab (ONGLYZA equiv)	-	NC
ZITUVIO TAB	-	NC
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB	-	B
INCRETIN MIMETIC AGENTS		
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
BYDUREON INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
BYDUREON PEN INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
BYETTA INJ (Step Therapy requires trial of VICTOZA or BYDUREON; Diagnosis Restricted – Type 2 Diabetes (E11))	RDX-ST	B
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
VICTOZA INJ (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
ADLYXIN INJ	-	NC
TANZEUM INJ	-	NC
INSULIN		
HUMALOG JR KWIKPEN INJ	-	B
HUMALOG KWIKPEN INJ	-	B
HUMALOG MIX INJ	-	B
HUMALOG MIX KWIKPEN INJ	-	B
HUMALOG PEN INJ	-	B
HUMULIN MIX INJ	OTC	B
HUMULIN MIX PEN INJ	OTC	B
HUMULIN N INJ	OTC	B
HUMULIN N PEN INJ	OTC	B
HUMULIN R INJ	OTC	B
HUMULIN R INJ U-500	-	B
HUMULIN R U-500 KWIKPEN INJ	-	B
INSULIN GLARGINE SOLN PEN-INJ	-	B
LEVEMIR FLEXTOUCH INJ	-	B
LEVEMIR INJ	-	B
LYUMJEV INJ	-	B
LYUMJEV KWIKPEN INJ	-	B
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	B
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
TOUJEO MAX SOLOSTAR INJ	-	B
TOUJEO SOLOSTAR INJ	-	B
TRESIBA FLEXTOUCH INJ	-	B
TRESIBA INJ	-	B
INSULIN LISPRO INJ (HUMALOG equiv)	-	G
ADMELOG INJ, HUMALOG INJ	-	NC
APIDRA INJ	-	NC
APIDRA SOLOSTAR INJ	-	NC
BASAGLAR INJ, LANTUS SOLOSTAR INJ, INSULIN GLARGINE SOLOSTAR INJ	-	NC
DEGLUDEC FLEXTOUCH INJ	-	NC
DEGLUDEC INJ	-	NC
FIASP FLEXTOUCH INJ	-	NC
FIASP INJ	-	NC
FIASP PENFILL INJ, FIASP PUMP CARTRIDGE	-	NC
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART PENFILL INJ	-	NC
INSULIN GLARGINE-YFGN (SINGLE PEN)	-	NC
INSULIN LISPRO KWIKPEN, INSULIN LISPRO JR KWIKPEN, ADMELOG SOLOSTAR INJ, HUMALOG TEMPO PEN	-	NC
INSULIN LISPRO PROTAMINE PEN INJ (HUMALOG equiv)	-	NC
LANTUS INJ, INSULIN GLARGINE INJ	-	NC
LYUMJEV TEMPO PEN INJ	-	NC
NOVOLIN 70/30 FLEXPEN INJ	OTC	NC
NOVOLIN 70/30 FLEXPEN RELION INJ	OTC	NC
NOVOLIN 70/30 INJ	OTC	NC
NOVOLIN 70/30 RELION INJ	OTC	NC
NOVOLIN N FLEXPEN INJ	OTC	NC
NOVOLIN N INJ	OTC	NC
NOVOLIN R FLEXPEN INJ	OTC	NC
NOVOLIN R INJ	OTC	NC
NOVOLIN R RELION INJ	OTC	NC
NOVOLOG FLEXPEN INJ	-	NC
NOVOLOG INJ	-	NC
NOVOLOG MIX FLEXPEN INJ	-	NC
NOVOLOG MIX INJ	-	NC
NOVOLOG PENFILL INJ	-	NC
REZVOGLAR INJ	-	NC
SEMGLEE INJ (SINGLE PEN)	-	NC
SEMGLEE SOLN	-	NC
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv)	-	G
MEGLITINIDE ANALOGUES		
nateglinide tab (STARLIX equiv)	-	G
repaglinide tab (PRANDIN equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB (QL= 1 tab/day)	QL	B
JARDIANCE TAB (QL= 1 tab/day)	QL	B
BEXAGLIFLOZN TAB	-	NC
DAPAGLIFLOZIN PROPRANEDIOL TAB 10MG	-	NC
DAPAGLIFLOZIN PROPRANEDIOL TAB 5MG	-	NC
INVOKANA TAB	-	NC
STEGLATRO TAB	-	NC
SULFONYLUREAS		
TOLBUTAMIDE TAB	-	B
gliimepiride tab (AMARYL equiv)	-	G
glipizide ER tab (GLUCOTROL XL equiv)	-	G
glipizide tab (GLUCOTROL equiv)	-	G
GLYBURID MCR TAB	-	G
glyburide tab (MICRONASE equiv)	-	G
TOLAZAMIDE TAB	-	G
GLIPIZIDE TAB	-	NC
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS		
DIPHENOXYLATE/ATROPINE LIQUID	-	B
loperamide hcl soln (LOPERAMIDE equiv)	OTC	NC
ANTIDIARRHEALS		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS		
MYTESI TAB	-	NC
ANTIDIARRHEAL AGENTS - MISC.		
REZYST CHEW TAB	-	NC
VSL #3 CAP	-	NC
ANTIDIARRHEAL COMBINATIONS		
EVIVO LIQUID	-	NC
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	G
opium tincture	-	G
loperamide cap (IMODIUM equiv)	-	NC
PAREGORIC TINCTURE	-	NC
ANTIDOTES		
ANTIDOTES		
VISTOGARD PAK	-	NC
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	B
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B
OPIOID ANTAGONISTS		
VIVITROL INJ	LMSP	B
naltrexone tab (REVIEWIA equiv)	-	G
EVZIO INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

ANTIDOTES AND SPECIFIC ANTAGONISTS

ANTIDOTES - CHELATING AGENTS

deferasirox granules packet (JADENU equiv)	LMSP	G
deferasirox tab (JADENU equiv)	LMSP	G
deferasirox tab for oral susp (EXJADE equiv)	LMSP	G
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G
FERRIPROX TAB 1000MG (TWICE DAILY)	-	NC
JADENU SPRINKLE	-	NC

ANTIDOTES AND SPECIFIC ANTAGONISTS

CETYLEV TAB	-	NC
-------------	---	----

OPIOID ANTAGONISTS

KLOXXADO NASAL SPRAY	-	B
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	B
OPVEE NASAL SPRAY	-	B
ZIMHI SOLN	-	B
naloxone hcl nasal spray (NARCAN equiv)	OTC	G
naloxone inj	-	G
naloxone prefilled inj	-	G
NARCAN NASAL SPRAY	OTC	G
EVZIO INJ	-	NC

ANTIEMETICS

5-HT3 RECEPTOR ANTAGONISTS

ANZEMET TAB (QL= 9 tabs/fill)	QL	B
GRANISOL SOLN (QL= 60ml/fill)	QL	B
SANCUSO PATCH (QL= 4 patches/fill)	QL	B
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	G
ondansetron ODT (ZOFTRAN equiv)	-	G
ondansetron soln (ZOFTRAN equiv)	-	G
ONDANSETRON TAB	-	G
ondansetron tab (ZOFTRAN equiv)	-	G
SUSTOL INJ	-	NC
ZUPLENZ SL FILM	-	NC

ANTIEMETICS - ANTICHOLINERGIC

meclizine chew tab (BONINE equiv) (Rx Only)	-	G
meclizine tab (ANTIVERT equiv) (Rx Only)	-	G
scopolamine patch (TRANSDERM-SCOP equiv)	-	G
trimethobenzamide cap (TIGAN equiv)	-	G
ANTIVERT TAB, MECLIZINE TAB	-	NC

ANTIEMETICS - MISCELLANEOUS

AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	B
CESAMET CAP	-	B
dronabinol cap (MARINOL equiv)	PA	G
doxylamine/pyridoxine dr tab (DICLEGIS equiv)	-	NC
SYNDROS SOLN	-	NC

SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS

VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	B
--	-------	---

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	MSP	OTC
RS	Prior Authorization	QL	Over-the-Counter
ST	Restricted to Specialist	SF	RDX
	Step Therapy	VAC	Restricted to Diagnosis
			SMKG
			Smoking Cessation
			¢
			RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	G
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	G
EMEND CAP	-	NC
EMEND SUSP	-	NC

ANTIFUNGALS

ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)

BREXAFEMME TAB	-	NC
----------------	---	----

ANTIFUNGALS

flucytosine cap (ANCOBON equiv)	-	G
griseofulvin micro tab (GRIFULVIN V equiv)	-	G
griseofulvin susp (GRIFULVIN equiv)	-	G
griseofulvin tab (GRIS-PEG equiv)	-	G
nystatin powder	-	G
nystatin tab	-	G
terbinafine tab (LAMISIL equiv)	-	G

IMIDAZOLE-RELATED ANTIFUNGALS

NOXAFIL PAK	-	B
SPORANOX SOLN	PA	B
fluconazole susp (DIFLUCAN equiv)	-	G
fluconazole tab (DIFLUCAN equiv)	-	G
itraconazole cap (SPORANOX equiv)	-	G
itraconazole soln (SPORANOX equiv)	PA	G
ketoconazole tab (NIZORAL equiv)	-	G
posaconazole DR tab (NOXAFIL equiv) (QL= 93 tabs/30 days)	PA-QL	G
posaconazole susp (NOXAFIL equiv) (QL= 525ml/26 days)	PA-QL	G
voriconazole susp (VFEND equiv)	-	G
voriconazole tab (VFEND equiv)	-	G
CRESEMBA CAP	-	NC
NOXAFIL TAB	-	NC
SPORANOX CAP	-	NC
TOLSURA CAP	-	NC
VFEND SUSP	-	NC
VIVJOA CAP	-	NC

ANTIHISTAMINES

ANTIHISTAMINES - ALKYLAMINES

DEXCHLORPHENIRAMINE SYRUP	-	NC
MICLARA LIQUID	-	NC
RYCLORA SOLN	-	NC

ANTIHISTAMINES - ETHANOLAMINES

CARBINOXAMINE SOLN	-	G
carbinoxamine tab (PALGIC equiv)	-	G
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	G
KARBINAL ER SUSP	-	NC
RYVENT TAB	-	NC

ANTIHISTAMINES - NON-SEDATING

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	OTC	Limited Distribution
PA	Plan Exclusion	MSP	RDX	Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	SMKG	Restricted to Diagnosis
ST	Prior Authorization	SF	¢	Smoking Cessation
	Restricted to Specialist	VAC		RxCENTS
	Step Therapy			

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
CLARINEX SYRUP	-	EXC
CLARINEX TAB	-	EXC
CLARITIN CAP	OTC	EXC
CLARITIN CHEW TAB	OTC	EXC
DES Loratadine ODT	-	EXC
desloratadine tab (CLARINEX equiv)	-	EXC
levocetirizine soln (XYZAL equiv)	-	EXC
levocetirizine tab (XYZAL equiv)	-	EXC
loratadine cap (CLARITIN equiv)	OTC	EXC
XYZAL SOLN	-	EXC
XYZAL TAB	-	EXC
ZYRTEC CHILD CHEW TAB	OTC	EXC
ZYRTEC CHILD CHEW ALLERGY	OTC	NC
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine supp (PHENERGAN equiv)	-	G
promethazine syrup	-	G
promethazine tab (PHENERGAN equiv)	-	G
PROMETHEGAN SUPP	-	G
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	G
cyproheptadine tab	-	G
ANTIHYPERLIPIDEMICS		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB (QL= 1 tab/day)	PA-QL	B
ANTIHYPERLIPIDEMICS - COMBINATIONS		
EZETIMIBE/ATORVASTATIN TAB	-	NC
ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (This strength excluded from coverage)	-	NC
NEXLIZET TAB	-	NC
OMEGA-3 RX PAK COMPLETE	-	NC
ROSZET TAB	-	NC
ANTIHYPERLIPIDEMICS - MISC.		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	G
VASCEPA CAP (QL= 4 caps/day)	PA-QL	G
icosapent ethyl cap (VASCEPA equiv)	-	NC
KYNAMRO INJ	-	NC
BILE ACID SEQUESTRANTS		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	G
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	G
cholestyramine powder (QUESTRAN equiv)	-	G
cholestyramine powder pack (QUESTRAN equiv)	-	G
colesevelam pack (WELCHOL equiv)	-	G
colesevelam tab (WELCHOL equiv)	-	G
colestipol granule (COLESTID equiv)	-	G
colestipol powder packet (COLESTID equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
colestipol tab (COLESTID equiv)	-	G
WELCHOL PACK	-	NC
WELCHOL TAB	-	NC
FIBRIC ACID DERIVATIVES		
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	G
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	G
fenofibric acid DR cap (TRILIPIX equiv)	-	G
gemfibrozil tab (LOPID equiv)	-	G
ANTARA CAP, FENOFIBRATE MICRONIZED CAP	-	NC
ANTARA CAP, LOFIBRA CAP	-	NC
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC
FENOFIBRATE CAP, LIPOFEN CAP	-	NC
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC
FENOFIBRIC TAB, FIBRICOR TAB	-	NC
TRIGLIDE TAB	-	NC
TRILIPIX CAP	-	NC
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab (LIPITOR equiv)	-	\$0
lovastatin tab (MEVACOR equiv)	-	\$0
pravastatin tab (PRAVACHOL equiv)	-	\$0
rosuvastatin tab (CRESTOR equiv)	-	\$0
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0
ATORVALIQ SUSP (Members age 9 or older require Prior Authorization)	PA	B
EZALLOR SPRINKLE CAP (Prior Authorization Required for members age 9 years and older)	PA	B
FLOLIPID SUSP (Members age 9 or older require Prior Authorization)	PA	B
ALTOPREV TAB	-	NC
CRESTOR TAB	-	NC
fluvastatin cap (LESCOL equiv)	-	NC
fluvastatin ER tab (LESCOL XL equiv)	-	NC
LESCOL CAP	-	NC
LESCOL XL TAB	-	NC
LIPITOR TAB	-	NC
LIVALO TAB	-	NC
pitavastatin calcium tab (LIVALO equiv)	-	NC
simvastatin tab 80mg (ZOCOR equiv)	-	NC
ZOCOR TAB 80MG	-	NC
ZYPITAMAG TAB	-	NC
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	G
ZETIA TAB	-	NC
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
JUXTAPID CAP	-	NC
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv)	-	G
NIACOR TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
NIASPAN ER TAB	-	NC
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	B
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	B
ANTIHYPERTENSIVES		
ACE INHIBITORS		
QBRELIS SOLN (Prior Authorization required for members age 9 or older)	PA	B
benazepril tab (LOTENSIN equiv)	-	G
captopril tab (CAPOTEN equiv)	-	G
enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for members age 9 or older)	PA	G
enalapril tab (VASOTEC equiv)	-	G
fosinopril tab (MONOPRIL equiv)	-	G
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	G
moexipril tab (UNIVASC equiv)	-	G
PERINDOPRIL TAB	-	G
perindopril tab (ACEON equiv)	-	G
quinapril tab (ACCUPRIL equiv)	-	G
ramipril cap (ALTACE equiv)	-	G
trandolapril tab (MAVIK equiv)	-	G
AGENTS FOR PHEOCHROMOCYTOMA		
phenoxybenzamine cap (DIBENZYLINE equiv)	-	G
DEMSEER CAP	-	NC
metyrosine cap (DEMSEER equiv)	-	NC
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
irbesartan tab (AVAPRO equiv)	-	G
losartan tab (COZAAR equiv)	-	G
olmesartan tab (BENICAR equiv)	-	G
telmisartan tab (MICARDIS equiv)	-	G
valsartan tab (DIOVAN equiv)	-	G
ATACAND TAB	-	NC
candesartan tab (ATACAND equiv)	-	NC
DIOVAN TAB	-	NC
EDARBI TAB	-	NC
VALSARTAN SOLN	-	NC
ANTIADRENERGIC ANTIHYPERTENSIVES		
CATAPRES-TTS PATCH	-	B
clonidine patch (CATAPRES-TTS equiv)	-	G
clonidine tab (CATAPRES equiv)	-	G
doxazosin tab (CARDURA equiv)	-	G
guanfacine IR tab (TENEX equiv)	-	G
METHYLDOPA TAB	-	G
methyldopa tab (ALDOMET equiv)	-	G
prazosin cap (MINIPRESS equiv)	-	G
terazosin cap (HYTRIN equiv)	-	G
NEXICLON XR TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
ANTIHYPERTENSIVE COMBINATIONS		
ACCURETIC TAB	-	B
TEKTURN HCT TAB (Step Therapy requires trial of valsartan/hctz)	ST	B
amlodipine/benazepril cap (LOTREL equiv)	-	G
amlodipine/valsartan tab (EXFORGE equiv)	-	G
atenolol/chlorthalidone tab (TENORETIC equiv)	-	G
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	G
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	G
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	G
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	G
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	G
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	G
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	G
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB	-	G
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	G
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	G
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	G
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	G
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	G
QUINAPRIL/HCTZ TAB	-	G
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	G
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	G
amlodipine/olmesartan tab (AZOR equiv)	-	NC
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	NC
AZOR TAB	-	NC
BENICAR HCT TAB	-	NC
BYVALSON TAB	-	NC
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	NC
DUTOPROL TAB	-	NC
EDARBYCLOR TAB	-	NC
MICARDIS HCT TAB	-	NC
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv)	-	NC
PRESTALIA TAB	-	NC
TELMISARTAN/AMLODIPINE TAB	-	NC
telmisartan/amlodipine tab (TWINSTA equiv)	-	NC
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC
TRANDOLAPRIL/VERAPAMIL ER TAB	-	NC
TRIBENZOR TAB	-	NC
ANTIHYPERTENSIVES - MISC.		
VECAMYL TAB	-	NC
DIRECT RENIN INHIBITORS		
aliskiren tab (TEKTURN equiv)	-	G
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPRA equiv)	-	G
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

ANTIHYPERTENSIVES Cont.

minoxidil tab (LONITEN equiv)	-	G
-------------------------------	---	---

ANTI-INFECTIVE AGENTS - MISC.

ANTI-INFECTIVE AGENTS - MISC.

FIRST METRONIDAZOLE SUSP	-	B
LIKMEZ SUSP (Prior Authorization required for members age 9 or older)	PA	B
PRIMSOL SOLN	-	B
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	PA-QL	B
XIFAXAN TAB 550MG (QL= 2 tabs/day)	PA-QL	B
metronidazole tab (FLAGYL equiv)	-	G
pentamidine neb soln (NEBUPENT equiv)	-	G
tinidazole tab (TINDAMAX equiv)	-	G
TRIMETHOPRIM TAB	-	G
trimethoprim tab (PROLOPRIM equiv)	-	G
AEMCOLO TAB	-	NC
IMPAVIDO CAP	-	NC
metronidazole cap (FLAGYL equiv)	-	NC

ANTI-INFECTIVE MISC. - COMBINATIONS

HYOPHEN TAB	-	B
hyophen tab (PROSED DS equiv)	-	G
smz/tmp (DS) tab (BACTRIM DS equiv)	-	G
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	G
UTA cap	-	NC

ANTIPROTOZOAL AGENTS

ALINIA SUSP (QL= 60ml/3 days)	PA-QL	B
LAMPIT TAB (Restricted to Infectious Disease Specialist)	RS	B
atovaquone susp (MEPRON equiv)	-	G
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	G

GLYCOPEPTIDES

FIRVANQ SOLN	-	G
FIRVANQ SOLN 50MG/ML	-	G
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	G
vancomycin hcl soln (VANCOMYCIN equiv)	-	NC
VANCOMYCIN ORAL SOLN	-	NC
VANCOMYCIN SOLN	-	NC

LEPROSTATICS

dapsone tab	-	G
-------------	---	---

LINCOSAMIDES

clindamycin cap (CLEOCIN equiv)	-	G
clindamycin soln (CLEOCIN equiv)	-	G
clindamycin cap 300mg (CLEOCIN equiv)	-	NC

MONOBACTAMS

CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	B
--	-------	---

OXAZOLIDINONES

SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	B
linezolid susp (Restricted to Infectious Disease Specialist)	RS	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	Limited Distribution
PA	Plan Exclusion	INF	Over-the-Counter
RS	LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP	Restricted to Diagnosis
ST	PA Prior Authorization	QL	Smoking Cessation
	RS Restricted to Specialist	SF	RxCENTS
	ST Step Therapy	VAC	
		LD	
		OTC	
		RDX	
		SMKG	
		¢	

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	G
PLEUROMUTILINS		
XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist)	QL-RS	B
POLYMYXINS		
colistimethate inj (COLY-MYCIN M equiv)	LMSP	B
URINARY ANTI-INFECTIVES		
MONUROL GRANULE PACK	-	B
fosfomycin tromethamine powder pack (MONUROL equiv)	-	G
methenamine hippurate tab (HIPREX equiv)	-	G
methenamine mandelate tab	-	G
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	G
nitrofurantoin monohydrate cap (MACROBID equiv)	-	G
nitrofurantoin susp (FURADANTIN equiv) (Covered for members age 9 or younger)	-	G
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	NC
NITROFURANTOIN SUSP	-	NC
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	G
MALARONE TAB	-	NC
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC
ANTIMALARIALS		
KRINTAFEL TAB	-	B
chloroquine tab (ARALEN equiv)	-	G
hydroxychloroquine tab (PLAQUENIL equiv)	-	G
mefloquine tab (LARIAM equiv)	-	G
primaquine tab (PRIMAQUINE equiv)	-	G
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	G
ARAKODA TAB	-	NC
QUALAQUIN CAP	-	NC
quinine sulfate cap (QUALAQUIN equiv)	-	NC
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	B
pyridostigmine CR tab (MESTINON equiv)	-	G
pyridostigmine tab (MESTINON equiv)	-	G
pyridostigmine soln (MESTINON equiv)	-	G
PYRIDOSTIGMINE TAB 30MG	-	NC
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	B
ANTIMYCOBACTERIAL AGENTS		
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	B
PRIFTIN TAB	-	B
ethambutol tab (MYAMBUTOL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS Cont.		
isoniazid syrup (ISONIAZID equiv)	-	G
isoniazid tab	-	G
pyrazinamide tab	-	G
rifabutin cap (MYCOBUTIN equiv)	-	G
rifampin cap (RIFADIN equiv)	-	G
cycloserine cap (CYCLOSERINE CAP equiv)	-	NC
SIRTURO TAB	-	NC
TRECTOR TAB	-	NC

ANTINEOPLASTICS

ALKYLATING AGENTS

HEXALEN CAP	-	B
-------------	---	---

ANTIMETABOLITES

TABLOID TAB	-	B
mercaptapurine tab (PURINETHOL equiv)	-	G
methotrexate tab (Trexall equiv)	-	G
TREXALL TAB	-	NC

ANTINEOPLASTIC ENZYME INHIBITORS

ZOLINZA CAP	LMSP-PA-SF	B
-------------	------------	---

ANTINEOPLASTICS MISC.

ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B
ALFERON-N INJ	LMSP	B
INTRON-A INJ	MSP	B
MATULANE CAP	-	B
hydroxyurea cap (HYDREA equiv)	-	G
tretinoin cap (VESANOID equiv)	LMSP	G

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

MESNEX TAB	LMSP	B
leucovorin tab	-	G

TOPOISOMERASE I INHIBITORS

HYCAMTIN CAP	LMSP-PA	B
--------------	---------	---

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

ALKYLATING AGENTS

CYCLOPHOSPHAMIDE TAB	-	B
GLEOSTINE/LOMUSTINE CAP	-	B
MYLERAN TAB	LMSP	B
cyclophosphamide cap	-	G
MELPHALAN TAB	-	G
temozolomide cap (TEMODAR equiv)	LMSP	G
bendamustine hcl for iv soln (TREANDA equiv)	-	NC
LEUKERAN TAB	-	NC
TREANDA INJ	-	NC

ANTIMETABOLITES

azacitidine inj (VIDAZA equiv)	MSP	B
JYLAMVO SOLN, XATMEP SOLN (Prior Authorization required for members age 9 or older)	PA	B
PURIXAN SUSP (Members age 9 or older require Prior Authorization)	PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
capecitabine tab (XELODA equiv)	LMSP	G
METHOTREXATE INJ	-	G
ONUREG TAB	-	NC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
AVASTIN INJ	MSP-PA	B
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	B
LENVIMA CAP (QL= 3 caps/day; Only available through Optum 877-445-6874)	LD-PA-QL	B
FRUZAQLA CAP	-	NC
ANTINEOPLASTIC - ANTIBODIES		
ARZERRA INJ	MSP-PA	B
RITUXAN INJ	MSP-PA	B
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
HERCEPTIN INJ	MSP-PA	B
TUKYSA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
ANTINEOPLASTIC - EGFR INHIBITORS		
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
VIZIMPRO TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B
erlotinib tab (TARCEVA equiv) (QL= 1 tab/day)	LMSP-PA-QL-SF	G
erlotinib tab 25mg (TARCEVA equiv) (QL= 3 tabs/day)	LMSP-PA-QL-SF	G
gefitinib tab (IRESSA equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G
IRESSA TAB	-	NC
TARCEVA TAB	-	NC
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP	LMSP-PA-SF	B
ODOMZO CAP	LMSP-PA-SF	B
DAURISMO TAB	-	NC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
anastrozole tab (ARIMIDEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
exemestane tab (AROMASIN equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
EMCYT CAP	-	B
ERLEADA TAB (QL= 4 tabs/day)	LMSP-PA-QL	B
ERLEADA TAB 240MG (QL= 1 tab/day)	LMSP-PA-QL	B
EULEXIN CAP	-	B
FIRMAGON INJ	MSP	B
FLUTAMIDE CAP	-	B
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	B
NUBEQA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B
ORGOVYX TAB (QL= 30 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
ORSERDU TAB (QL= 3 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
ORSERDU TAB 345MG (QL= 1 tab/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
ZOLADEX INJ	MSP	B
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tabs/day)	LMSP-QL	G
bicalutamide tab (CASODEX equiv)	-	G
flutamide cap (EULEXIN equiv)	-	G
letrozole tab (FEMARA equiv)	-	G
megestrol susp (MEGACE equiv)	-	G
megestrol tab (MEGACE equiv)	-	G
nilutamide tab (NILANDRON equiv)	LMSP	G
toremifene tab (FARESTON equiv)	-	G
abiraterone acetate tab 500mg (ZYTIGA equiv)	-	NC
AKEEGA TAB	-	NC
HYDROXYPROGESTERONE CAPROATE INJ	-	NC
XTANDI CAP	-	NC
XTANDI TAB 40MG	-	NC
XTANDI TAB 80MG	-	NC
YONSA TAB	-	NC
ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS		
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP (QL= 21 caps/28 days)	MSP-PA-QL	B
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS		
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ANTINEOPLASTIC - XPO1 INHIBITORS		
XPOVIO PAK (QL= 32 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ANTINEOPLASTIC COMBINATIONS		
INQOVI TAB (QL= 5 tabs/28 days)	MSP-PA-QL	B
KISQALI PAK (QL= 91 tabs/28 days)	LMSP-PA-QL	B
LONSURF TAB	MSP-PA	B
ANTINEOPLASTIC ENZYME INHIBITORS		
ALECENSA CAP (QL= 8 caps/day)	LMSP-PA-QL	B
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B
BORTEZOMIB INJ	MSP-PA	B
bortezomib inj (VELCADE equiv)	MSP-PA	B
BOSULIF TAB	MSP-PA-SF	B
BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
BRUKINSA CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B
CALQUENCE CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	generic = small letters	LD	BRANDS = CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	INF	OTC	Over-the-Counter
PA	Prior Authorization	MSP	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	QL	SMKG	Smoking Cessation
ST	Step Therapy	SF	¢	RxCENTS
		VAC		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	B
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
COPIKTRA CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
COTELLIC TAB (QL= 3 tabs/day)	LMSP-PA-QL	B
FOTIVDA CAP (QL= 21 caps/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B
GAVRETO CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B
ICLUSIG TAB (QL= 1 tab/day; Only available through AcariaHealth 800-511-5144)	LD-PA-QL-SF	B
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	B
IMBRUVICA CAP 140MG (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
IMBRUVICA TAB 420MG, 560MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	B
JAYPIRCA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
KISQALI TAB (QL= 63 tabs/28 days)	LMSP-PA-QL	B
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LORBRENA TAB 25MG (QL= 1 tab/day)	MSP-PA-QL-SF	B
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	B
LUMAKRAS TAB (QL= 8 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LUMAKRAS TAB 320MG (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LYNPARZA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
MEKINIST SOLN	LMSP-PA	B
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	LMSP-PA-QL	B
MEKINIST TAB 2MG (QL= 1 tab/day)	LMSP-PA-QL	B
MEKTOVI TAB (QL= 6 tabs/day)	MSP-PA-QL	B
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	B
PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
PIQRAY TAB	LMSP-PA-SF	B
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
RETEVMO CAP (QL= 4 caps/day)	LMSP-PA-QL-SF	B
REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ROZLYTREK CAP (QL= 3 caps/day)	LMSP-PA-QL	B
ROZLYTREK PAK (QL= 6 packs/day)	LMSP-PA-QL	B
RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	B
RYDAPT CAP (QL= 56 caps/28 days)	LMSP-PA-QL	B
SPRYCEL TAB	LMSP-PA-SF	B
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B
TABRECTA TAB (QL= 4 tabs/day)	LMSP-PA-QL-SF	B
TAFINLAR CAP	LMSP-PA	B
TAFINLAR TAB	LMSP-PA	B
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	B
TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day)	MSP-PA-QL-SF	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
TASIGNA CAP	LMSP-PA-SF	B
TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
temsirolimus inj (TORISEL equiv)	MSP-PA	B
TEPMETKO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
TIBSOVO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
TORISEL INJ	MSP-PA	B
TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
VERZENIO TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	B
XALKORI SPRINKLE CAP (QL= 4 caps/day)	MSP-PA-QL-SF	B
XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
ZELBORAF TAB (QL= 8 tabs/day)	LMSP-PA-QL	B
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
ZYKADIA CAP (QL= 3 caps/day)	LMSP-PA-QL-SF	B
ZYKADIA TAB (QL= 3 tabs/day)	LMSP-PA-QL-SF	B
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	G
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	LMSP-PA-QL-SF	G
imatinib tab (GLEEVEC equiv)	LMSP	G
lapatinib ditosylate tab (TYKERB equiv)	LMSP-PA	G
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	LMSP-PA-QL-SF	G
sorafenib tosylate tab (NEXAVAR equiv)	LMSP-PA-SF	G
sunitinib malate cap (SUTENT equiv)	LMSP-PA-SF	G
AFINITOR DISPERZ TAB	-	NC
AFINITOR TAB	-	NC
ALUNBRIG PAK	-	NC
AUGTYRO CAP	-	NC
BOSULIF CAP	-	NC
IBRANCE CAP	-	NC
IBRANCE TAB	-	NC
IMBRUVICA TAB 140MG	-	NC
IMBRUVICA TAB 280MG	-	NC
INREBIC CAP	-	NC
OGSIVEO TAB	-	NC
OJJAARA TAB	-	NC
SCSEMBLIX TAB	-	NC
SUTENT CAP	-	NC
TALZENNA CAP 0.1MG	-	NC
TALZENNA CAP 0.35MG	-	NC
TRUQAP TAB	-	NC
TYKERB TAB	-	NC
VANFLYTA TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
VOTRIENT TAB	-	NC
ANTINEOPLASTICS MISC.		
bexarotene cap (TARGRETIN equiv)	LMSP-PA-SF	G
BESREMI INJ	-	NC
SYLATRON INJ	-	NC
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
IWILFIN TAB	-	NC
MITOTIC INHIBITORS		
ETOPOSIDE CAP	LMSP	B
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	G
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	G
trihexyphenidyl tab (ARTANE equiv)	-	G
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	G
tolcapone tab (TASMAR equiv)	-	G
ANTIPARKINSON DOPAMINERGICS		
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	B
NEUPRO PATCH	PA	B
amantadine cap (SYMMETREL equiv)	-	G
amantadine syrup (SYMMETREL equiv)	-	G
amantadine tab	-	G
bromocriptine cap (PARLODEL equiv)	-	G
bromocriptine tab (PARLODEL equiv)	-	G
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	G
carbidopa/levodopa ODT (PARCOPA equiv)	-	G
carbidopa/levodopa tab (SINEMET equiv)	-	G
pramipexole ER tab (MIRAPEX ER equiv)	-	G
pramipexole tab (MIRAPEX equiv)	-	G
ropinirole ER tab (REQUIP XL equiv)	-	G
ropinirole tab (REQUIP equiv)	-	G
DUOPA ENTERAL SUSP	-	NC
GOCOVRI CAP	-	NC
MIRAPEX ER TAB	-	NC
RYTARY CAP	-	NC
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
XADAGO TAB (QL= 1 tab/day)	PA-QL	B
rasagiline tab (AZILECT equiv)	¢	G
selegiline cap (ELDEPRYL equiv)	-	G
selegiline tab (ELDEPRYL equiv)	-	G
ZELAPAR ODT	-	NC

ANTIPARKINSON AND RELATED THERAPY AGENTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIPARKINSON AND RELATED THERAPY AGENTS Cont.		
ANTIPARKINSON ANTICHOLINERGICS		
trihexyphenidyl elixir (ARTANE equiv)	-	G
TRIHEXYPHENIDYL SOLN	-	G
ANTIPARKINSON COMT INHIBITORS		
ONGENTYS CAP (QL= 1 tab/day, 30 tabs per fill)	PA-QL	B
ANTIPARKINSON DOPAMINERGICS		
INBRIJA INH POWDER (QL= 10 caps/day)	PA-QL	B
CARBIDOPA/LEVODOPA ODT	-	G
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	G
APOKYN INJ	-	NC
apomorphine inj (APOKYN equiv)	-	NC
DHIVY TAB	-	NC
KYNMOBI FILM	-	NC
KYNMOBI TITRATION KIT	-	NC
OSMOLEX ER TAB	-	NC
REQUIP XL TAB	-	NC
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
lithium carbonate cap (ESKALITH ER equiv)	-	G
lithium carbonate ER tab (LITHOBID equiv)	-	G
lithium carbonate tab	-	G
ANTIPSYCHOTICS - MISC.		
EQUETRO CAP	-	B
lurasidone hcl tab (LATUDA equiv)	-	G
ziprasidone cap (GEODON equiv)	-	G
CAPLYTA CAP	-	NC
LATUDA TAB	-	NC
NUPLAZID CAP	-	NC
NUPLAZID TAB	-	NC
VRAYLAR CAP	-	NC
VRAYLAR PACK	-	NC
BENZISOXAZOLES		
FANAPT TAB (QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B
FANAPT TITRATION PACK (QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B
RISPERIDONE ODT	-	B
paliperidone ER tab (INVEGA equiv) (Step Therapy requires trial of ABILIFY or quetiapine ER)	ST	G
risperidone ODT (RISPERDAL M equiv)	-	G
risperidone soln (RISPERDAL equiv)	-	G
risperidone tab (RISPERDAL equiv)	-	G
INVEGA HAFYERA INJ	-	NC
INVEGA INJ	-	NC
INVEGA TAB	-	NC
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	G
haloperidol tab (HALDOL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.

DIBENZAPINES

asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	G
clozapine tab (CLOZARIL equiv)	-	G
loxapine cap (LOXITANE equiv)	-	G
olanzapine ODT (ZYPREXA equiv)	-	G
olanzapine tab (ZYPREXA equiv)	-	G
quetiapine tab (SEROQUEL equiv)	-	G
quetiapine XR tab (SEROQUEL XR equiv)	-	G
ADASUVE INHALER	-	NC
CLOZAPINE ODT	-	NC
clozapine odt tab (CLOZAPINE, FAZACLO equiv)	-	NC
CLOZAPINE ODT, FAZACLO ODT	-	NC
QUETIAPINE TAB	-	NC
SECUADO PATCH	-	NC
SEROQUEL XR TAB	-	NC
VERSACLOZ SUSP	-	NC

DIHYDROINDOLONES

MOLINDONE TAB	-	NC
---------------	---	----

PHENOTHIAZINES

chlorpromazine tab (THORAZINE equiv)	-	G
fluphenazine tab (PROLIXIN equiv)	-	G
perphenazine tab (TRILAFON equiv)	-	G
prochlorperazine supp (COMPAZINE equiv)	-	G
prochlorperazine tab (COMPAZINE equiv)	-	G
thioridazine tab (MELLARIL equiv)	-	G
trifluoperazine tab (STELAZINE equiv)	-	G
CHLORPROMAZINE CONC	-	NC

QUINOLINONE DERIVATIVES

aripiprazole soln (ABILIFY equiv)	-	G
aripiprazole tab (ABILIFY equiv)	-	G
ABILIFY MYCITE PACK	-	NC
ABILIFY MYCITE TAB	-	NC
aripiprazole ODT (ABILIFY equiv)	-	NC
REXULTI TAB	-	NC

THIOXANTHENES

thiothixene cap (NAVANE equiv)	-	G
--------------------------------	---	---

ANTISEPTICS & DISINFECTANTS

ANTISEPTICS & DISINFECTANTS

HYLAMEND GEL FIRST AID	-	NC
------------------------	---	----

IODINE ANTISEPTICS

IODOFLEX PAD	-	NC
--------------	---	----

ANTIVIRALS

ANTIRETROVIRALS

DESCOVY TAB	PA	\$0
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	\$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	generic = small letters	LD	BRANDS = CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	INF	Infertility	OTC
PA	Prior Authorization	MSP	Mandatory Specialty Pharmacy Program	Over-the-Counter
RS	Restricted to Specialist	QL	Quantity Limit	RDX
ST	Step Therapy	SF	Limited to two 15 day fills per month for first 3 months	Restricted to Diagnosis
		VAC	Vaccine Program	SMKG
				Smoking Cessation
				¢
				RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
APTIVUS CAP	-	B
APTIVUS SOLN	-	B
BIKTARVY TAB	-	B
CIMDUO TAB	-	B
COMPLERA TAB	-	B
CRIXIVAN CAP	-	B
DELSTRIGO TAB	-	B
DOVATO TAB	-	B
EDURANT TAB	-	B
EMTRIVA CAP	-	B
EMTRIVA SOLN	-	B
EVOTAZ TAB	-	B
FUZEON INJ	LMSP	B
GENVOYA TAB	-	B
INTELENCE TAB	-	B
INVIRASE CAP	-	B
INVIRASE TAB	-	B
ISENTRESS (HD) TAB	-	B
ISENTRESS CHEW TAB	-	B
ISENTRESS POWDER PACK	-	B
JULUCA TAB	-	B
KALETRA TAB	-	B
LEXIVA SUSP	-	B
NORVIR CAP	-	B
NORVIR POWDER PACK	-	B
NORVIR SOLN	-	B
ODEFSEY TAB	-	B
PIFELTRO TAB	-	B
PREZCOBIX TAB	-	B
PREZISTA SUSP	-	B
PREZISTA TAB	-	B
RESCRIPTOR TAB	-	B
REYATAZ POWDER PACK	-	B
RUKOBIA ER TAB (Restricted to Infectious Disease Specialist)	RS	B
SELZENTRY SOLN	-	B
SELZENTRY TAB	-	B
STRIBILD TAB	-	B
SUSTIVA TAB	-	B
SYMFI (LO) TAB	-	B
SYMTUZA TAB	-	B
TIVICAY PD TAB	-	B
TIVICAY TAB	-	B
TRIUMEQ PD TAB	-	B
TRIUMEQ TAB	-	B
TRIZIVIR TAB	-	B
VIDEX SOLN	-	B
VIRACEPT TAB	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
VIREAD TAB	-	B
abacavir soln (ZIAGEN equiv)	-	G
abacavir tab (ZIAGEN equiv)	-	G
abacavir/lamivudine tab (EPZICOM equiv)	-	G
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	G
atazanavir cap (REYATAZ equiv)	-	G
darunavir tab (PREZISTA equiv)	-	G
didanosine DR cap (VIDEX EC equiv)	-	G
DIDANOSINE DR CAP, VIDEX EC CAP	-	G
EFAVIRENZ CAP	-	G
efavirenz tab (SUSTIVA equiv)	-	G
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	G
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	G
emtricitabine cap (EMTRIVA equiv)	-	G
etravirine tab (INTELENCE equiv)	-	G
fosamprenavir tab (LEXIVA equiv)	-	G
lamivudine soln (EPIVIR equiv)	-	G
lamivudine tab (EPIVIR equiv)	-	G
lamivudine/zidovudine tab (COMBIVIR equiv)	-	G
lopinavir/ritonavir soln (KALETRA equiv)	-	G
lopinavir/ritonavir tab (KALETRA equiv)	-	G
maraviroc tab (SELZENTRY equiv)	-	G
NEVIRAPINE ER TAB (Step Therapy requires trial of nevirapine)	ST	G
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	G
NEVIRAPINE SUSP	-	G
nevirapine tab (VIRAMUNE equiv)	-	G
ritonavir tab (NORVIR equiv)	-	G
STAVUDINE CAP	-	G
stavudine cap (ZERIT equiv)	-	G
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	G
zidovudine cap (RETROVIR equiv)	-	G
zidovudine syrup (RETROVIR equiv)	-	G
zidovudine tab (RETROVIR equiv)	-	G
ATRIPLA TAB	-	NC
CABENUVA IM SUSP	-	NC
SUNLENCA TAB	-	NC
TYBOST TAB	-	NC
VIRAMUNE XR TAB	-	NC
VOCABRIA TAB	-	NC
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100MG (QL= 20 tabs/fill)	QL	B
PAXLOVID TAB 300-100MG (QL= 30 tabs/fill)	QL	B
CMV AGENTS		
GANCICLOVIR INJ	MSP	B
ganciclovir inj (CYTOVENE equiv)	MSP	B
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	LMSP-PA-QL	B
valganciclovir soln (VALCYTE equiv)	-	G
valganciclovir tab (VALCYTE equiv)	-	G
HEPATITIS AGENTS		
BARACLUDE SOLN (Members age 9 or older require Prior Authorization)	PA	B
EPIVIR HBV SOLN	-	B
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B
MAVYRET PAK (QL= 5 packs/day)	LMSP-PA-QL	B
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	B
PEGASYS INJ	LMSP	B
PEG-INTRON INJ	LMSP	B
REBETOL SOLN	LMSP	B
RIBAVIRIN CAP	LMSP	B
RIBAVIRIN TAB	LMSP	B
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B
VEMLIDY TAB	PA	B
VOSEVI TAB (QL= 1 tab/day)	LMSP-PA-QL	B
adefovir dipivoxil tab (HEPSERA equiv)	-	G
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	G
lamivudine tab 100mg (EPIVIR HBV equiv)	-	G
ribavirin cap (REBETOL equiv)	LMSP	G
DAKLINZA TAB	-	NC
EPCLUSA PAK	-	NC
EPCLUSA TAB	-	NC
HARVONI PELLETT PAK	-	NC
HARVONI TAB	-	NC
MODERIBA TAB	-	NC
OLYSIO CAP	-	NC
RIBAPAK TAB	-	NC
RIBAVIRIN TAB 400MG	-	NC
SOVALDI PELLETT PAK	-	NC
SOVALDI TAB	-	NC
TECHNIVIE TAB	-	NC
VIEKIRA XR TAB	-	NC
ZEPATIER TAB	-	NC
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	G
acyclovir susp (ZOVIRAX equiv)	-	G
acyclovir tab (ZOVIRAX equiv)	-	G
famciclovir tab (FAMVIR equiv)	-	G
valacyclovir tab (VALTREX equiv)	-	G
SITAVIG TAB	-	NC
INFLUENZA AGENTS		
RELENZA DISKHALER (QL= 1 inhaler/calendar year)	QL	B
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill, 1 fill/calendar year)	QL	G
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill, 1 fill/calendar year)	QL	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill, 1 fill per calendar year)	QL	G
RIMANTADINE TAB	-	NC
XOFLUZA TAB	-	NC
XOFLUZA TAB THERAPY PACK 40MG	-	NC
XOFLUZA TAB THERAPY PACK 80MG	-	NC
MISC. ANTIVIRALS		
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	\$0
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	B
RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS		
ribavirin inh soln (VIRAZOLE equiv)	-	NC
ASSORTED CLASSES		
CHELATING AGENTS		
D-PENAMINE TAB	-	B
ENZYMES		
XIAFLEX INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B
IMMUNOMODULATORS		
THALOMID CAP	MSP	B
IMMUNOSUPPRESSIVE AGENTS		
SANDIMMUNE SOLN 100MG/ML	-	B
azathioprine tab (IMURAN equiv)	-	G
cyclosporine cap (SANDIMMUNE equiv)	-	G
cyclosporine modified cap (NEORAL equiv)	-	G
cyclosporine modified soln (NEORAL equiv)	-	G
mycophenolate DR tab (MYFORTIC equiv)	-	G
mycophenolate mofetil cap (CELLCEPT equiv)	-	G
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	G
mycophenolate mofetil tab (CELLCEPT equiv)	-	G
sirolimus tab (RAPAMUNE equiv)	-	G
tacrolimus cap (PROGRAF equiv)	-	G
ENVARUSUS XR TAB	-	NC
POTASSIUM REMOVING RESINS		
VELTASSA POWDER	PA	B
sodium polystyrene powder (KAYEXALATE equiv)	-	G
sodium polystyrene susp (SPS equiv)	-	G
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	G
labetalol tab (NORMODYNE equiv)	-	G
carvedilol phosphate ER cap (COREG CR equiv)	-	NC
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	G
atenolol tab (TENORMIN equiv)	-	G
betaxolol tab (KERLONE equiv)	-	G
bisoprolol tab (ZEBETA equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

BETA BLOCKERS Cont.

metoprolol ER tab (TOPROL XL equiv)	-	G
metoprolol tab (LOPRESSOR equiv)	-	G
nebivolol hcl tab (BYSTOLIC equiv)	¢	G
KAPSPARGO CAP	-	NC

BETA BLOCKERS NON-SELECTIVE

SOTYLIZE SOLN 5MG/ML (Prior Authorization required for members age 9 or older)	PA	B
nadolol tab (CORGARD equiv)	-	G
pindolol tab (VISKEN equiv)	-	G
propranolol ER cap (INDERAL LA equiv)	-	G
propranolol oral soln 20mg/5ml (PROPRANOLOL equiv)	-	G
PROPRANOLOL SOLN	-	G
propranolol tab (INDERAL equiv)	-	G
sotalol AF tab (BETAPACE AF equiv)	-	G
sotalol tab (BETAPACE equiv)	-	G
timolol maleate tab (BLOCADREN equiv)	-	G
HEMANGEOL SOLN	-	NC
INDERAL XL CAP, INNOPRAN XL CAP	-	NC
SOTYLIZE SOLN	-	NC

BIOLOGICALS MISC

ALLERGENIC EXTRACTS

GRASTEK SL TAB	-	NC
ORALAIR SL TAB	-	NC
RAGWITEK SL TAB	-	NC

BIOLOGICALS MISC

ADAGEN INJ	MSP-PA	B
------------	--------	---

CALCIUM CHANNEL BLOCKERS

CALCIUM CHANNEL BLOCKER COMBINATIONS

CONSENSI TAB	-	NC
--------------	---	----

CALCIUM CHANNEL BLOCKERS

KATERZIA SUSP (Prior Authorization required for members age 9 or older)	PA	B
NORLIQVA ORAL SOLN (Members age 9 or older require Prior Authorization)	PA	B
amlodipine tab (NORVASC equiv)	-	G
diltiazem ER cap (CARDIZEM CD equiv)	-	G
diltiazem ER cap (CARDIZEM SR equiv)	-	G
diltiazem ER cap (DILACOR XR equiv)	-	G
diltiazem ER cap (TIAZAC equiv)	-	G
DILTIAZEM HCL COATED BEADS CAP ER 24HR 120MG	-	G
DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 120MG	-	G
diltiazem tab (CARDIZEM equiv)	-	G
felodipine ER tab (PLENDIL equiv)	-	G
isradipine cap (DYNACIRC equiv)	-	G
nifedipine cap (PROCARDIA equiv)	-	G
nifedipine ER tab (ADALAT CC equiv)	-	G
nimodipine cap (NIMOTOP equiv)	-	G
nisoldipine ER tab (SULAR equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	OTC	Limited Distribution
PA	Plan Exclusion	MSP	RDX	Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	SMKG	Restricted to Diagnosis
ST	Prior Authorization	SF	¢	Smoking Cessation
	Restricted to Specialist	VAC		RxCENTS
	Step Therapy			

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS Cont.		
NISOLDIPINE ER TAB 20MG, 30MG, 40MG	-	G
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	G
verapamil tab (CALAN equiv)	-	G
CONJUPRI TAB, LEVAMLODIPINE TAB	-	NC
diltiazem ER cap 120mg (CARDIZEM SR equiv)	-	NC
diltiazem ER tab (CARDIZEM LA equiv)	-	NC
nicardipine cap (CARDENE equiv)	-	NC
NYMALIZE SOLN	-	NC
VERAPAMIL CR CAP, VERELAN CAP	-	NC
verapamil SR cap (VERELAN equiv)	-	NC
VERELAN CAP	-	NC
VERELAN PM ER CAP 100MG, 300MG	-	NC
CARDIOTONICS		
CARDIAC GLYCOSIDES		
digoxin soln (LANOXIN equiv)	-	G
DIGOXIN SOLN 0.05MG/ML	-	G
digoxin tab (LANOXIN equiv)	-	G
digoxin tab 62.5mcg (LANOXIN equiv)	-	NC
LANOXIN INJ	-	NC
LANOXIN TAB 62.5MCG	-	NC
CARDIOVASCULAR AGENTS - MISC.		
CARDIAC MYOSIN INHIBITORS		
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
ENTRESTO TAB (QL= 2 tabs/day)	QL	B
amlodipine/atorvastatin tab (CADUET equiv)	-	NC
BIDIL TAB	-	NC
isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv)	-	NC
CARDIOVASCULAR ANTI-INFLAMMATORY/IMMUNE MODULATORS		
LODOCO TAB	-	NC
CARDIOVASCULAR SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITORS		
INPEFA TAB	-	NC
IMPOTENCE AGENTS		
CAVERJECT INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B
EDEX INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B
MUSE SUPP (QL= 6 supp/30 days; Step therapy requires trial of sildenafil)	QL-ST	B
sildenafil tab (VIAGRA equiv) (QL=6 tabs/30 days)	QL	G
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day)	QL	G
LEVITRA TAB	-	NC
STENDRA TAB	-	NC
tadalafil tab (CIALIS equiv)	-	NC
vardenafil ODT (STAXYN equiv)	-	NC
vardenafil tab (LEVITRA equiv)	-	NC
PERIPHERAL VASODILATORS		
ISOXSUPRINE TAB	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	generic = small letters	LD	BRANDS = CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	INF	OTC	Over-the-Counter
PA	Prior Authorization	MSP	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	QL	SMKG	Smoking Cessation
ST	Step Therapy	SF	¢	RxCENTS
		VAC		
		INF		
		MSP		
		QL		
		SF		
		VAC		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

CARDIOVASCULAR AGENTS - MISC. Cont.

PROSTAGLANDIN VASODILATORS

treprostinil inj 10mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
treprostinil inj 1mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
treprostinil inj 2.5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
treprostinil inj 5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
ORENITRAM TAB	-	NC
ORENITRAM TAB MONTH PAK	-	NC

PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS

OPSUMIT TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TRACLEER TAB 32MG (QL= 4 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G

PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS

TADLIQ SUSP (Members age 9 years or older require Prior Authorization)	MSP-PA	B
sildenafil susp (REVATIO equiv) (Members age 9 or older require Prior Authorization)	PA	G
sildenafil tab 20mg (REVATIO equiv)	PA	G
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	G
ADCIRCA TAB	-	NC
LIQREV SUSP	-	NC
REVATIO SUSP	-	NC

PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST

UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
UPTRAVI INJ	-	NC

PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR

ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
---	----------	---

SINUS NODE INHIBITORS

CORLANOR SOLN	PA	B
CORLANOR TAB	PA	B

TRANSTHYRETIN STABILIZERS

VYNDAMAX CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B

VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)

VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist)	QL-RS	B
--	-------	---

CEPHALOSPORINS

CEPHALOSPORINS - 1ST GENERATION

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
cefadroxil cap (DURICEF equiv)	-	G
cefadroxil susp (DURICEF equiv)	-	G
CEFADROXIL TAB	-	G
cefadroxil tab (DURICEF equiv)	-	G
cephalexin cap (KEFLEX equiv)	-	G
cephalexin susp (KEFLEX equiv)	-	G
cephalexin cap 750mg (KEFLEX equiv)	-	NC
CEPHALEXIN TAB	-	NC
KEFLEX CAP 750MG	-	NC

CEPHALOSPORINS - 2ND GENERATION

CEFACLOR ER TAB	-	B
CEFACLOR SUSP	-	B
CEFACLOR CAP	-	G
cefaclor cap (CECLOR equiv)	-	G
cefprozil susp (CEFZIL equiv)	-	G
cefprozil tab (CEFZIL equiv)	-	G
cefuroxime tab (CEFTIN equiv)	-	G

CEPHALOSPORINS - 3RD GENERATION

CEFDITOREN TAB	-	B
SPECTRACEF TAB	-	B
SUPRAX CAP	-	B
SUPRAX CHEW TAB	-	B
SUPRAX SUSP 500MG/5ML	-	B
cefdinir cap (OMNICEF equiv)	-	G
cefdinir susp (OMNICEF equiv)	-	G
cefixime cap (SUPRAX equiv)	-	G
cefixime susp (SUPRAX equiv)	-	G
cefpodoxime proxetil susp (VANTIN equiv)	-	G
cefpodoxime proxetil tab (VANTIN equiv)	-	G

CONTRACEPTIVES

COMBINATION CONTRACEPTIVES - ORAL

amethyst tab (LYBREL equiv)	-	\$0
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	\$0
cryselle tab	-	\$0
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	\$0
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	\$0
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	\$0
nortrel tab (OVCON 35 equiv)	-	\$0
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	\$0
tri-legest tab (ESTROSTEP FE equiv)	-	\$0
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
TYBLUME TAB	-	\$0
VELIVET PAK	-	\$0
velivet tab (CYCLESSA equiv)	-	\$0
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0
viorele tab, kariva tab (MIRCETTE equiv)	-	\$0
BALCOLTRA TAB	-	NC
drosiprone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	NC
FALESSA KIT	-	NC
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	NC
LO LOESTRIN TAB	-	NC
loestrin 21 tab	-	NC
loestrin tab	-	NC
NATAZIA TAB	-	NC
NEXTSTELLIS TAB	-	NC
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	NC
norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv)	-	NC
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	NC
SAFYRAL TAB	-	NC
TAYTULLA CAP	-	NC
YAZ TAB, YASMIN 28 TAB	-	NC
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
zafemy patch (XULANE equiv)	-	\$0
TWIRLA PATCH	-	NC
COMBINATION CONTRACEPTIVES - VAGINAL		
NUVARING	-	\$0
ANNOVERA RING	-	NC
eluryng vaginal ring (NUVARING equiv)	-	NC
COPPER CONTRACEPTIVES - IUD		
PARAGARD IUD	-	\$0
EMERGENCY CONTRACEPTIVES		
ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0
PLAN B TAB	OTC	\$0
PROGESTIN CONTRACEPTIVES - IMPLANTS		
NEXPLANON IMPLANT	-	\$0
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0
DEPO-PROVERA INJ	-	NC
PROGESTIN CONTRACEPTIVES - IUD		
MIRENA IUD	-	\$0
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	\$0
SLYND TAB	-	NC

CORTICOSTEROIDS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
GLUCOCORTICOSTEROIDS		
ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Members age 9 or older require Prior Authorization)	PA-QL	B
ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Members age 9 or older require Prior Authorization)	PA-QL	B
CORTISONE ACETATE TAB	-	B
PREDNISOLONE SOLN	-	B
PREDNISONE SOLN	-	B
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	B
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	B
SOLU-MEDROL INJ 2GM	-	B
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	G
budesonide SR cap (ENTOCORT EC equiv)	-	G
DEXAMETHASONE CONC	-	G
dexamethasone elixir	-	G
dexamethasone sodium phosphate inj	-	G
DEXAMETHASONE SOLN	-	G
dexamethasone tab (DECADRON equiv)	-	G
hydrocortisone tab (CORTEF equiv)	-	G
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	G
methylprednisolone dose pack (MEDROL equiv)	-	G
methylprednisolone tab (MEDROL equiv)	-	G
methylprednisolone sod succinate inj (SOLU-MEDROL equiv)	-	G
prednisolone soln	-	G
prednisolone soln (PEDIAPRED equiv)	-	G
prednisone tab (DELTASONE equiv)	-	G
triamcinolone acetonide inj (KENALOG equiv)	-	G
AGAMREE SUSP	-	NC
ALKINDI SPRINKLE CAP	-	NC
CORTEF TAB	-	NC
deflazacort tab (EMFLAZA equiv)	-	NC
DEPO-MEDROL INJ	-	NC
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	NC
dexamethasone pak (DEXPAK equiv)	-	NC
DEXAMETHASONE TAB	-	NC
DEXPAK TAB	-	NC
DXEVO 11-DAY PAK	-	NC
EMFLAZA SUSP	-	NC
EMFLAZA TAB	-	NC
EOHILIA SUSP	-	NC
FLO-PRED SUSP	-	NC
KENALOG INJ	-	NC
KENALOG INJ, TRIAMCINOLONE ACE INJ	-	NC
LIDOLOG KIT	-	NC
MEDROL TAB	-	NC
MILLIPRED DP PAK	-	NC
MILLIPRED TAB	-	NC
ORAPRED ODT TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
ORTIKOS ER CAP	-	NC
prednisolone ODT (ORAPRED equiv)	-	NC
PREDNISOLONE ODT TAB	-	NC
prednisolone tab (MILLIPRED equiv)	-	NC
prednisone pack	-	NC
PREDNISON/DIPHENHYDRAMINE KIT	-	NC
RAYOS TAB	-	NC
SOLU-MEDROL INJ	-	NC
SOLU-MEDROL PF INJ	-	NC
TARPEYO CAP	-	NC

MINERALOCORTICIDS

fludrocortisone tab (FLORINEF equiv)	-	G
--------------------------------------	---	---

COUGH/COLD/ALLERGY

ANTITUSSIVES

HYCODAN SYRUP	-	B
benzonatate cap (TESSALON equiv)	-	G
hydrocodone/homatropine syrup (HYCODAN equiv)	-	G
tussigon tab (HYCODAN equiv)	-	G
benzonatate cap 150mg (ZONATUSS equiv)	-	NC
ZONATUSS CAP 150MG	-	NC

COUGH/COLD/ALLERGY COMBINATIONS

CLARINEX-D TAB	-	EXC
SEMPREX-D CAP	-	EXC
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	G
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	G
HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	G
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	G
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	QL	G
promethazine DM syrup	-	G
PROMETHAZINE VC SYRUP	-	G
promethazine VC syrup (PHENERGAN VC equiv)	-	G
PROMETHAZINE VC/CODEINE SYRUP	-	G
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	G
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	G
DURAVENT PE TAB	-	NC
guaifenesin-DM oral liquid (ROBITUSSIN equiv)	-	NC
HYCOFENIX SOLN	-	NC
INTENSE COUGH LIQUID	-	NC
MUCINEX LIQUID	-	NC
POLY-TUSSIN DM SYRUP	-	NC
TUSSICAPS	-	NC
TUXARIN ER TAB	-	NC
TUZISTRA XR SUSP	-	NC

EXPECTORANTS

SSKI ORAL SOLN	-	B
potassium iodide oral soln (SSKI equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	LD
PA	Plan Exclusion	Infertility	Limited Distribution
RS	Lumicera Mandatory Specialty Pharmacy Program	MSP	OTC
ST	Prior Authorization	Mandatory Specialty Pharmacy Program	Over-the-Counter
	Restricted to Specialist	QL	RDX
	Step Therapy	Quantity Limit	Restricted to Diagnosis
		SF	SMKG
		Limited to two 15 day fills per month for first 3 months	Smoking Cessation
		VAC	¢
		Vaccine Program	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
GUAIFENESEN SYRUP	-	NC
MUCINEX TAB	-	NC
MISC. RESPIRATORY INHALANTS		
NEBUSAL NEB SOLN	-	B
sodium chloride neb soln (HYPER-SAL equiv)	-	G
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	G
DERMATOLOGICALS		
ACNE PRODUCTS		
dapsone gel 5% (ACZONE equiv)	-	B
PRASCION RA CREAM	-	B
DIFFERIN OTC GEL 0.1%	OTC	EXC
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	G
amneesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	G
clindamycin gel (CLEOCIN GEL equiv)	-	G
clindamycin lotion (CLEOCIN- T equiv)	-	G
clindamycin pad (CLEOCIN-T equiv)	-	G
clindamycin topical soln (CLEOCIN-T equiv)	-	G
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	G
erythromycin gel	-	G
erythromycin pad	-	G
erythromycin soln	-	G
erythromycin/benzoyl peroxide gel	-	G
sodium sulfacetamide lotion (KLARON equiv)	-	G
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	G
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	G
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	G
tretinoin cream (QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G
tretinoin gel (QL= 20gm/fill)	PA-QL	G
tretinoin gel (RETIN-A GEL equiv) (QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G
ABSORICA CAP	-	NC
ABSORICA LD CAP	-	NC
ADAPALENE SOLN	-	NC
adapalene cream (DIFFERIN equiv)	-	NC
adapalene gel (DIFFERIN equiv)	-	NC
ADAPALENE LOTION (DIFFERIN equiv)	-	NC
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	NC
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC
AKLIEF CREAM	-	NC
ALTRENO LOTION	-	NC
AMZEEQ FOAM	-	NC
ARAZLO LOTION	-	NC
ATRALIN GEL	-	NC
AVAR AEROSOL FOAM	-	NC
AVAR GEL	-	NC
AVAR PAD	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
AVAR-E LS CREAM 10-2%	-	NC
AZELEX CREAM	-	NC
BENZAC WASH	-	NC
BENZOYL PEROXIDE CREAM	OTC	NC
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC
benzoyl peroxide/hydrocortisone lotion (VANOXIDE-HC equiv)	-	NC
CLENIA PLUS SUSP	-	NC
CLINDACIN KIT	-	NC
clindamycin foam (EVOCLIN equiv)	-	NC
clindamycin gel 1% (CLEOCIN GEL equiv)	-	NC
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv)	-	NC
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	NC
clindamycin/tretinoin gel (ZIANA equiv)	-	NC
CLINDAVIX KIT	-	NC
dapsone gel (ACZONE equiv)	-	NC
DAPSONE GEL 7.5%	-	NC
EPIDUO FORTE GEL 0.3-2.5%	-	NC
EPIDUO GEL 0.1-2.5%	-	NC
EPSOLAY CREAM	-	NC
ERY PAD	-	NC
EVOCLIN FOAM	-	NC
FABIOR AEROSOL FOAM	-	NC
isotretinoin cap 25mg (ABSORICA equiv)	-	NC
isotretinoin cap 35mg (ABSORICA equiv)	-	NC
NUCARACLINPA KIT	-	NC
NUCARARXPAK KIT	-	NC
ONEXTON GEL 1.2-3.75%	-	NC
PLEXION CREAM 9.8-4.8%	-	NC
RETIN-A CREAM	-	NC
RETIN-A GEL	-	NC
RETIN-A MICRO GEL 0.04%, 0.1%	-	NC
RETIN-A MICRO GEL 0.08%, 0.06%	-	NC
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	NC
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	NC
sodium sulfacetamide/sulfur emulsion 10-1% (ROSAC WASH equiv)	-	NC
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	NC
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	NC
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	NC
SODIUM SULFACETAMIDE/SULFUR SUSP	-	NC
sodium sulfacetamide/sulfur susp (PLEXION TS equiv)	-	NC
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	NC
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC
sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv)	-	NC
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	NC
sulfacetamide sodium/sulfur cream 9.8-4.8% (PLEXION equiv)	-	NC
SUMADAN WASH 9-4.5%	-	NC
SUMADEN XLT KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
SUMAXIN WASH	-	NC
tretinoin gel 0.05% (ATRALIN equiv)	-	NC
tretinoin gel pump 0.04% (TRETINOIN GEL PUMP 0.04% equiv)	-	NC
tretinoin gel pump 0.1% (TRETINOIN GEL PUMP 0.1% equiv)	-	NC
TRETIN-X CREAM	-	NC
TWYNEO CREAM	-	NC
WINLEVI CREAM	-	NC
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS		
VEREGEN OINT	-	B
AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES		
RENOVA CREAM	-	EXC
KYBELLA INJ	-	NC
ANALGESICS - TOPICAL		
BACLOFEN CREAM COMPOUND KIT	-	B
TRAMADOL COMPOUND KIT	-	NC
ANTIBIOTICS - TOPICAL		
CORTISPORIN CREAM	-	B
CORTISPORIN OINT	-	B
gentamicin sulfate cream	-	G
gentamicin sulfate oint	-	G
mupirocin oint (BACTROBAN OINT equiv)	-	G
ALTABAX OINT	-	NC
BACTROBAN CREAM	-	NC
CENTANY OINT	-	NC
mupirocin cream (BACTROBAN CREAM equiv)	-	NC
NEO-SYNALAR CREAM	-	NC
XEPI CREAM	-	NC
ANTIFUNGALS - TOPICAL		
clotrimazole cream (LOTRIMIN AF equiv) (Rx Only)	OTC	EXC
NIZORAL A-D SHAMPOO	OTC	EXC
nizoral a-d shampoo (NIZORAL equiv)	OTC	EXC
ciclopirox cream (LOPROX CREAM equiv)	-	G
ciclopirox nail soln (PENLAC equiv)	-	G
ciclopirox shampoo (LOPROX equiv) (Step Therapy requires trial of ketoconazole shampoo)	ST	G
econazole cream (SPECTAZOLE equiv) (QL= 30gm/30 days)	QL	G
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	G
ketoconazole cream (NIZORAL CREAM equiv)	-	G
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	G
nystatin cream (MYCOSTATIN CREAM equiv)	-	G
nystatin oint	-	G
nystatin topical powder	-	G
ALCORTIN A GEL (iodoquinol/hydrocortisone/aloe polysaccharide gel equiv)	-	NC
ALOQUIN GEL	-	NC
CICLODAN KIT	-	NC
ciclopirox gel (LOPROX equiv)	-	NC
ciclopirox topical susp (LOPROX equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	MSP	Over-the-Counter
RS	Prior Authorization	QL	Restricted to Diagnosis
ST	Restricted to Specialist	SF	Smoking Cessation
	Step Therapy	VAC	RxCENTS
			¢

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
clotrimazole/betamethasone cream (LOTRISONE equiv)	-	NC
clotrimazole/betamethasone lotion (LOTRISONE equiv)	-	NC
ECONASIL KIT	-	NC
ECOZA FOAM	-	NC
ERTACZO CREAM	-	NC
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC
EXELDERM SOLN	-	NC
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC
HIXDEFRIMA SOLN	-	NC
iodoquinol/hydrocortisone cream 1.9-1% (VYTONE equiv)	-	NC
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	NC
JUBLIA SOLN	-	NC
KERYDIN SOLN	-	NC
LOTRIMIN AF CREAM	-	NC
LOTRISONE CREAM	-	NC
LULICONAZOLE CREAM, LUZU CREAM	-	NC
MENTAX CREAM	-	NC
NAFTIFINE CREAM	-	NC
naftifine cream (NAFTIN equiv)	-	NC
naftifine gel (NAFTIN equiv)	-	NC
naftifine hcl gel 2% (NAFTIN equiv)	-	NC
NAFTIN CREAM	-	NC
NAFTIN GEL	-	NC
NAFTIN GEL 2%	-	NC
nystatin/triamcinolone cream	-	NC
nystatin/triamcinolone oint	-	NC
ONYCHO-MED KIT	-	NC
oxiconazole nitrate cream (OXISTAT equiv)	-	NC
OXISTAT CREAM	-	NC
OXISTAT LOTION	-	NC
PEDIZOLPAK THERAPY PACK	-	NC
PENLAC SOLN	-	NC
tavaborole soln (KERYDIN equiv)	-	NC
VYTONE CREAM 1.9-1%	-	NC
XOLEGEL	-	NC
ZOLPAK KIT	-	NC

ANTI-INFLAMMATORY AGENTS - TOPICAL

DICLOFENAC PATCH, FLECTOR PATCH (QL= 30 patches/fill; Step Therapy requires trial of celecoxib)	QL-ST	B
VOPAC 5 CREAM	-	B
VOLTAREN GEL	OTC	EXC
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	G
diclofenac soln 1.5% (PENNSAID equiv)	-	G
diclofenac sodium gel kit (VENNGEL equiv)	-	NC
diclofenac sodium soln (XRYLIX equiv)	-	NC
diclofenac sodium soln 2% (PENNSAID SOLN equiv)	-	NC
DICLONA GEL	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	Limited Distribution
PA	Plan Exclusion	MSP	Over-the-Counter
RS	LMSP Lumicera Mandatory Specialty Pharmacy Program	QL	Restricted to Diagnosis
ST	PA Prior Authorization	SF	Smoking Cessation
	RS Restricted to Specialist	VAC	RxCENTS
	ST Step Therapy		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
DICLOTREX PAK	-	NC
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC
LICART PATCH	-	NC
NAPROXEN CREAM COMPOUND KIT	-	NC
PENNSAID SOLN	-	NC
REXAPHENAC CREAM	-	NC
VENNGEL ONE KIT	-	NC
VOPAC CREAM	-	NC
VOPAC GB CREAM	-	NC
XRYLIX PAK	-	NC
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
FLUOROURACIL SOLN	-	B
PICATO GEL (QL= 1 box/fill)	QL	B
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Optum Pharmacy 877-445-6874)	LD-PA-QL	B
bexarotene gel (TARGRETIN equiv)	LMSP-PA	G
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	G
fluorouracil cream (EFUDEX CREAM equiv)	-	G
CARAC CREAM	-	NC
FLUORAC CREAM	-	NC
FLUOROPLEX CREAM	-	NC
FLUOROURACIL CREAM 0.5%	-	NC
KLISYRI OINT	-	NC
ROAOXIA GEL	-	NC
SOLARAVIX PAK	-	NC
TARGRETIN GEL	-	NC
ANTIPRURITICS - TOPICAL		
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	-	NC
DOXEPIN HCL CREAM	-	NC
ANTIPSORIATICS		
METHOXSALEN CAP	-	B
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	LMSP-PA-QL	B
SKYRIZI INJ 75MG/0.83ML (QL= 2 inj/84 days)	LMSP-PA-QL	B
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
TAZORAC CREAM 0.05%	PA	B
TREMFYA INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	B
acitretin cap (SORIATANE equiv)	-	G
calcipotriene cream (DOVONEX CREAM equiv)	-	G
calcipotriene oint	-	G
calcipotriene soln (DOVONEX SOLN equiv)	-	G
methoxsalen cap (OXSORALEN ULTRA equiv)	-	G
tazarotene cream 0.1% (TAZORAC equiv)	PA	G
BIMZELX INJ	-	NC
calcipotriene cream (TRIONEX equiv)	-	NC
CALCIPOTRIENE FOAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
CALCIPOTRIENE FOAM, SORILUX FOAM	-	NC
CALCITRIOL OINT	-	NC
CALSODORE PAK	-	NC
COSENTYX INJ (1-PACK)	-	NC
COSENTYX INJ (2-PACK)	-	NC
COSENTYX INJ 300MG/2ML	-	NC
SILIQ INJ	-	NC
SOTYKTU TAB	-	NC
tazarotene gel (TAZORAC equiv)	-	NC
TAZORAC CREAM	-	NC
TRIONEX PACK	-	NC
VECTICAL OINT	-	NC
VTAMA CREAM	-	NC
ANTISEBORRHEIC PRODUCTS		
selenium sulfide lotion	OTC	EXC
selenium sulfide lotion 2.5% (SELSUN equiv)	-	G
selenium sulfide shampoo (SELSEB equiv)	-	G
sodium sulfacetamide wash (OVACE WASH equiv)	-	G
ESKATA SOLN	-	NC
OVACE PLUS CREAM	-	NC
OVACE PLUS LOTION	-	NC
OVACE PLUS SHAMPOO	-	NC
OVACE PLUS FOAM	-	NC
PROMISEB CREAM	-	NC
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC
sodium sulfacetamide gel (OVACE equiv)	-	NC
sodium sulfacetamide shampoo (OVACE equiv)	-	NC
ZORYVE FOAM	-	NC
ANTIVIRALS - TOPICAL		
acyclovir oint (ZOVIRAX OINT equiv)	-	G
acyclovir cream (ZOVIRAX equiv)	-	NC
DENAVIR CREAM	-	NC
penciclovir cream (DENAVIR equiv)	-	NC
XERESE CREAM	-	NC
ZOVIRAX CREAM	-	NC
ZOVIRAX OINT	-	NC
BURN PRODUCTS		
SULFAMYLLON CREAM	-	B
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	G
CORTICOSTEROIDS - TOPICAL		
BETAMETHASONE AUGMENTED GEL	-	B
EPIFOAM AEROSOL	-	B
PRAMOSONE E CREAM	-	B
PREDNICARBATE CREAM	-	B
PREDNICARBATE OIN	-	B
alclometasone cream (ACLOVATE equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
alclometasone oint (ACLOVATE OINT equiv)	-	G
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	G
betamethasone augmented gel	-	G
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	G
betamethasone augmented oint (DIPROLENE OINT equiv)	-	G
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	G
betamethasone dipropionate lotion	-	G
betamethasone dipropionate oint (DIPROSONE OINT equiv)	-	G
betamethasone valerate cream	-	G
betamethasone valerate lotion	-	G
betamethasone valerate oint	-	G
clobetasol foam (OLUX equiv)	PA	G
clobetasol lotion (CLOBEX equiv)	PA	G
clobetasol propionate cream (TEMOVATE equiv)	-	G
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	G
clobetasol propionate gel (TEMOVATE GEL equiv)	-	G
clobetasol propionate oint (TEMOVATE equiv)	-	G
clobetasol propionate soln (TEMOVATE equiv)	-	G
clobetasol shampoo (CLOBEX equiv)	-	G
clobetasol spray (CLOBEX equiv)	-	G
desonide cream (DESOWEN equiv)	-	G
desonide oint (DESOWEN equiv)	-	G
desoximetasone oint 0.25% (TOPICORT equiv)	-	G
FLUOCINOLONE ACET CREAM	-	G
fluocinolone acetonide cream	-	G
fluocinolone acetonide oil	-	G
fluocinolone acetonide oint	-	G
fluocinolone acetonide soln	-	G
fluocinonide cream 0.05% (LIDEX equiv)	-	G
fluocinonide emollient cream	-	G
fluocinonide gel	-	G
fluocinonide oint	-	G
fluocinonide soln	-	G
fluticasone propionate cream (CUTIVATE equiv)	-	G
fluticasone propionate oint (CUTIVATE equiv)	-	G
halobetasol propionate cream (ULTRAVATE equiv)	-	G
halobetasol propionate oint (ULTRAVATE equiv)	-	G
hydrocortisone cream (PROCTOCORT equiv)	-	G
hydrocortisone lotion (HYTONE equiv)	-	G
hydrocortisone oint	-	G
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	G
mometasone cream (ELOCON equiv)	-	G
mometasone oint (ELOCON equiv)	-	G
mometasone soln (ELOCON equiv)	-	G
triamcinolone cream	-	G
triamcinolone lotion	-	G
triamcinolone oint	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ALA-SCALP LOTION	-	NC
AMCINONIDE CREAM 0.1%	-	NC
AMCINONIDE LOTION	-	NC
amcinonide oint 0.1% (AMCINONIDE OINT equiv)	-	NC
AMCINONIDE OINTMENT	-	NC
APEXICON E CREAM (PSORCON E equiv)	-	NC
BESER KIT 0.05%	-	NC
betamethasone valerate foam (LUXIQ equiv)	-	NC
BRYHALI LOTION	-	NC
calcipotriene/betamethasone dipropionate susp (TACLONEX equiv)	-	NC
calcipotriene/betamethasone oint (TACLONEX equiv)	-	NC
CAPEX SHAMPOO	-	NC
clobetasol E foam (OLUX E equiv)	-	NC
CLOBETAVIX KIT	-	NC
CLOBEX LOTION	-	NC
CLOBEX SHAMPOO	-	NC
CLOCORTOLONE CREAM	-	NC
clocortolone pivalate cream	-	NC
CLODERM CREAM	-	NC
CORDRAN CREAM 0.025%	-	NC
CORDRAN OINTMENT	-	NC
CORDRAN TAPE	-	NC
CUTIVATE LOTION	-	NC
DERMACINRX KIT	-	NC
DESONATE GEL	-	NC
desonide gel	-	NC
desonide lotion (DESOWEN equiv)	-	NC
DESOWEN CREAM	-	NC
DESOWEN CREAM KIT	-	NC
DESOWEN LOTION	-	NC
DESOWEN LOTION KIT	-	NC
DESOWEN OINT	-	NC
DESOWEN OINT KIT	-	NC
desoximetasone cream (TOPICORT CREAM equiv)	-	NC
desoximetasone cream 0.05% (TOPICORT equiv)	-	NC
desoximetasone gel (TOPICORT equiv)	-	NC
desoximetasone oint 0.05% (TOPICORT equiv)	-	NC
DIFLORASONE CREAM, PSORCON CREAM	-	NC
diflorasone oint	-	NC
DUOBRII LOTION	-	NC
ENSTILAR FOAM	-	NC
fluocinonide cream 0.1%	-	NC
FLUOPAR KIT	-	NC
FLUOVIX PAK	-	NC
flurandrenolide cream (CORDRAN equiv)	-	NC
flurandrenolide lotion (CORDRAN equiv)	-	NC
flurandrenolide oint (CORDRAN equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
FLUTICASONE LOTION	-	NC
fluticasone propionate lotion (CUTIVATE equiv)	-	NC
halcinonide cream (HALOG equiv)	-	NC
HALOBETASOL AER	-	NC
halobetasol propionate foam (HALOBETASOL equiv)	-	NC
HALOG CREAM	-	NC
HALOG OINT	-	NC
HALOG SOLN	-	NC
halonate pac kit (ULTRAVATE KIT equiv)	-	NC
HC BUTYRATE CREAM	-	NC
HC BUTYRATE SOLN	-	NC
HC/PRAMOXINE CREAM 1-2.35%	-	NC
HC-LIDOCAINE CREAM	-	NC
hydrocortisone butyrate cream (LOCOID equiv)	-	NC
HYDROCORTISONE BUTYRATE LIPO CREAM	-	NC
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC
hydrocortisone butyrate oint (LOCOID equiv)	-	NC
hydrocortisone butyrate soln (LOCOID equiv)	-	NC
hydrocortisone lotion (LOCOID equiv)	-	NC
hydrocortisone lotion 2% (ALA SCALP equiv)	-	NC
HYDROCORTISONE PAK	-	NC
hydrocortisone valerate cream (WESTCORT equiv)	-	NC
hydrocortisone valerate oint (WESTCORT equiv)	-	NC
HYDROXYM GEL	-	NC
IMPEKLO LOTION	-	NC
IMPOYZ CREAM	-	NC
LOCOID CREAM	-	NC
LOCOID LIPOCREAM	-	NC
LOCOID OINT	-	NC
LOCOID SOLN	-	NC
LUXIQ FOAM	-	NC
MEXPAROX HC CREAM	-	NC
MICORT-HC CREAM	-	NC
NOVACORT GEL	-	NC
OLUX E FOAM	-	NC
OLUX FOAM	-	NC
PANDEL CREAM	-	NC
paramox hc gel (NOVACORT GEL equiv)	-	NC
PRAMOSONE CREAM 1-1%	-	NC
PRAMOSONE CREAM 1-2.5%	-	NC
PRAMOSONE LOTION	-	NC
PRAMOSONE OINT	-	NC
QUINIXIL PAK	-	NC
SERNIVO SPRAY	-	NC
SILALITE PAK MIS	-	NC
TACLONEX SUSP	-	NC
TASOPROL CREAM KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
TEMOVATE CREAM	-	NC
TEMOVATE OINT	-	NC
TOPICORT CREAM	-	NC
TOPICORT CREAM 0.05%	-	NC
TOPICORT GEL	-	NC
TOPICORT OINT	-	NC
TOPICORT OINT 0.05%	-	NC
TOVET KIT	-	NC
triamcinolone acetonide oint (TRIANEX equiv)	-	NC
triamcinolone spray (KENALOG equiv)	-	NC
TRIANEX OINT	-	NC
TRILOCICLO KIT	-	NC
ULTRAVATE LOTION	-	NC
ULTRAVATE PAC KIT	-	NC
VANOS CREAM	-	NC
VERDESO FOAM	-	NC
WESTCORT OINT	-	NC
WYNZORA CREAM	-	NC
ECZEMA AGENTS		
ADBRY INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B
CIBINQO TAB (QL= 1 tab/day)	LMSP-PA-QL	B
DUPIXENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
DUPIXENT PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
OPZELURA CREAM (QL= 4 tubes/30 days for the first two months; then QL= 12 tubes/year thereafter)	PA-QL	B
EMOLLIENT/KERATOLYTIC AGENTS		
DERMASORB XM KIT	-	B
CARMOL LOTION	-	NC
KERAFOAM	-	NC
KERALAC CREAM	-	NC
UMECTA EMULSION	-	NC
UMECTA PD EMULSION	-	NC
UMECTA SUSP	-	NC
URAMAXIN CREAM	-	NC
URAMAXIN GEL	-	NC
urea cream	-	NC
urea emulsion	-	NC
urea gel (URAMAXIN equiv)	-	NC
urea lotion (KERALAC LOTION equiv)	-	NC
UREA NAIL KIT	-	NC
UREA SUSP	-	NC
urea susp 40% (UMECTA equiv)	-	NC
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	OTC	EXC
ammonium lactate lotion (LAC-HYDRIN equiv)	OTC	EXC
LACTIC ACID LOTION	-	G
HYLINATE LOTION	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ENZYMES - TOPICAL		
SANTYL OINT (QL= 90gm/30 days)	QL	B
vasolex oint (XENADERM equiv)	-	NC
XENADERM OINT	-	NC
HAIR GROWTH AGENTS		
bimatoprost ophth soln	-	EXC
finasteride tab (PROPECIA equiv)	-	EXC
LATISSE SOLN	-	NC
LITFULO CAP	-	NC
HAIR REDUCTION AGENTS		
VANIQA CREAM	-	EXC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	G
IMIQUIMOD CREAM 3.75%	-	NC
imiquimod cream 3.75% (IMIQUIMOD equiv)	-	NC
ZYCLARA CREAM	-	NC
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older)	-	G
tacrolimus oint (PROTOPIC OINT equiv)	-	G
OXIANUJO CREAM	-	NC
KERATOLYTIC/ANTIMITOTIC AGENTS		
CONDYLOX GEL	-	B
PODOCON SOLN	-	B
SALEX SHAMPOO	-	B
podofilox gel (CONDYLOX equiv)	-	G
PODOFILOX SOLN	-	G
podofilox soln (CONDYLOX equiv)	-	G
salicylic acid shampoo (SALEX equiv)	-	G
ATRIX SYSTEM KIT	-	NC
GEAMETDRAY GEL	-	NC
METDRAY GEL	-	NC
SALEX LOTION KIT	-	NC
SALICATE LIQUID	-	NC
salicylic acid soln	-	NC
salicylic acid cream (CERAVE PSORIASIS equiv)	-	NC
SALIMEZ FORTE CREAM	-	NC
UREA/SALICYLIC CREAM	-	NC
XALIX SOL	-	NC
LOCAL ANESTHETICS - TOPICAL		
LIDOCAINE GEL	-	B
lidocaine cream 3% (LIDAMANTLE equiv)	-	G
lidocaine gel (GLYDO equiv)	-	G
lidocaine gel (XYLOCAINE equiv)	-	G
lidocaine oint (QL= 36gm/fill)	QL	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	QL	G
lidocaine soln (XYLOCAINE equiv)	-	G
lidocaine/prilocaine cream (EMLA equiv)	-	G
ADAZIN CREAM	-	NC
ANASTIA LOTION	-	NC
APRIZIO PAK KIT	-	NC
capsaicin/menthol topical patch (SINELEE equiv)	-	NC
DERMALID PAK	-	NC
GEN7T LOTION	-	NC
GEN7T PAD 3.5%	-	NC
GEN7T PLUS LOTION	-	NC
GEN7T PLUS PAD	-	NC
L.E.T. GEL	-	NC
LIDO/MENTHOL SPRAY	-	NC
LIDO/RAC/TET GEL	-	NC
LIDOCAINE CREAM	-	NC
lidocaine cream 3.88% (LIDOTRAL CREAM equiv)	-	NC
lidocaine lotion	-	NC
lidocaine oint/transparent dressing kit	-	NC
lidocaine patch 3.5% (GEN7T equiv)	-	NC
lidocaine patch 4% (LIDODERM equiv)	-	NC
LIDOCIN GEL	-	NC
LIDODERM PATCH 4%	-	NC
LIDOSTREAM KIT	-	NC
LIDOTRAL CREAM (lidocaine cream equiv)	-	NC
LIDOTREX GEL	-	NC
LIDOVEX CREAM	-	NC
MEDI-PATCH W/LIDOCAINE PATCH	-	NC
MENTHOREAL10 THERAPY PACK	-	NC
MICROVIX LP PAK	-	NC
NENDRUX GEL	-	NC
nulido pad (NULIDO equiv)	-	NC
NUVAKAAN II KIT	-	NC
PLIAGLIS CREAM	-	NC
PLIAGLIS KIT	-	NC
PROZENA PAD	-	NC
SILVERA PAD	-	NC
SOLAICE PATCH	-	NC
SYNVEXIA TC CREAM	-	NC
WPR PLUS	-	NC
ZILACAINE PAK	-	NC
ZYLOTROL-L KIT	-	NC
MISC. DERMATOLOGICAL PRODUCTS		
NEOSALUS FOAM	-	NC
NEOSALUS LOTION	-	NC
MISC. TOPICAL		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
DRYSOL SOLN	-	G
DERMACINRX CREAM	-	NC
HYCLODEX SOLN	-	NC
QBREXZA PAD	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OINT	-	NC
PIGMENTING-DEPIGMENTING AGENTS		
hydroquinone cream (LUSTRA equiv)	-	EXC
TRI-LUMA CREAM	-	EXC
EPIQUIN MICRO CREAM	-	NC
hydroquinone cream/sunscreen (LUSTRA ULTRA equiv)	-	NC
hydroquinone micro cream (EPIQUIN MICRO equiv)	-	NC
MELQUIN 3 SOLN	-	NC
NUQUIN HP CREAM	-	NC
ROSACEA AGENTS		
FINACEA FOAM	-	B
brimonidine tartrate gel (MIRVASO equiv)	-	EXC
MIRVASO GEL	-	EXC
RHOFADE CREAM	-	EXC
azelaic acid gel (FINACEA equiv)	-	G
metronidazole cream (METROCREAM equiv)	-	G
metronidazole gel 0.75% (METROGEL equiv)	-	G
metronidazole gel 1% (METROGEL equiv) (Step Therapy requires trial of metronidazole gel 0.75%)	ST	G
metronidazole lotion (METROLOTION equiv)	-	G
DAZOMON GEL	-	NC
DOXYCYCLINE CAP, ORACEA CAP	-	NC
IVERMECTIN CREAM	-	NC
ivermectin cream (SOOLANTRA equiv)	-	NC
NORITATE CREAM	-	NC
ROSADAN KIT	-	NC
SOOLANTRA CREAM	-	NC
ZILXI FOAM	-	NC
SCABICIDES & PEDICULICIDES		
NATROBA SUSP (QL= 1 bottle/fill)	QL	B
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	B
LINDANE SHAMPOO	-	G
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	G
permethrin cream (ELIMITE CREAM equiv)	-	G
CROTAN LOTION	-	NC
IVERMECTIN LOTION	-	NC
SKLICE LOTION	-	NC
SCAR TREATMENT PRODUCTS		
SCARCIN GEL	-	NC
scarcin gel (SCARCIN equiv)	-	NC
SCARCIN LIQUID ROLL-ON	-	NC
SILIPAC KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
WOUND CARE PRODUCTS		
REGRANEX GEL (QL= 30gm/fill)	QL	B
ALEVICYN SOLN DERMAL	-	NC
BIAFINE EMULSION	-	NC
cicatrace kit (REXASIL equiv)	-	NC
COLLANEX EXTERNAL POWDER	-	NC
FILSUVEZ GEL	-	NC
KERAMATRIX	-	NC
KERASTAT CREAM	-	NC
KERASTAT GEL	-	NC
WOUND-DRESSING GELS	-	NC
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC BIOLOGICALS		
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC
DIAGNOSTIC DRUGS		
GLUCAGEN INJ	-	B
GLUCAGON DIAGNOSTIC INJ	-	NC
MACRILEN PACK	-	NC
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP	OTC	NC
DIAGNOSTIC TESTS		
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC-PA	B
ACCU-CHEK GUIDE TEST STRIP	OTC-PA	B
ACCU-CHEK SMARTVIEW TEST STRIP	OTC-PA	B
ACCU-CHEK TEST STRIP	OTC-PA	B
TEST STRIP (all other test strips)	OTC-PA	B
COVID-19 TEST	OTC	EXC
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EXC
CUE HEALTH MONITOR	OTC	EXC
CLINISTIX TEST STRIP	OTC	G
KETO-DIASTIX TEST STRIP	OTC	G
KETOSTIX	OTC	G
ONETOUCH TEST STRIP	OTC	G
ONETOUCH VERIO TEST STRIP	OTC	G
ACCU-CHEK GUIDE TEST STRIP	OTC	NC
FREESTYLE INSULINX TEST STRIP	OTC	NC
FREESTYLE PRECISION NEO TEST STRIP	OTC	NC
FREESTYLE TEST STRIP	OTC	NC
PRECISION XTRA KETONE TEST STRIP	OTC	NC
PRECISION XTRA TEST STRIP	--OTC	NC
RADIOGRAPHIC CONTRAST MEDIA		
OMNIPAQUE SOLN	-	NC
SITZMARKS CAP	-	NC
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS Cont.		
ASTAMED MYO CAP	-	EXC
DEPLIN CAP	-	EXC
ELIGEN B12 TAB	-	EXC
FALESSA TAB	-	EXC
FOLTANX TAB	-	EXC
GLYGEST PAK	-	EXC
L-METHYLFOLATE TAB	-	EXC
LUVIRA CAP	-	EXC
METANX CAP	-	EXC
OLLIZAC POWDER	-	EXC
PODIAPN CAP	-	EXC
XAQUIL XR TAB	-	EXC
XYZBAC TAB	-	EXC
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	B
PANCREAZE CAP, PERTZYE CAP, ULTRESA CAP, ZENPEP CAP	-	NC
SUCRAID SOLN	-	NC
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	G
acetazolamide tab	-	G
methazolamide tab (NEPTAZANE equiv)	-	G
dichlorphenamide tab (KEVEYIS equiv)	-	NC
KEVEYIS TAB	-	NC
DIURETIC COMBINATIONS		
AMILORIDE/HCTZ TAB	-	G
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	G
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	G
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	G
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	G
LOOP DIURETICS		
FUROSCIX KIT (QL= 8 inj/fill; Only available through BioMatrix Specialty Pharmacy 855-359-9679)	LD-QL	B
bumetanide tab (BUMEX equiv)	-	G
FUROSEMIDE SOLN	-	G
furosemide soln (LASIX equiv)	-	G
furosemide tab (LASIX equiv)	-	G
torseamide tab (DEMADEX equiv)	-	G
EDECIN TAB	-	NC
ethacrynic tab (EDECIN equiv)	-	NC
SOAANZ TAB	-	NC
POTASSIUM SPARING DIURETICS		
CAROSPIR SUSP (Prior Authorization required for members age 9 or older)	PA	B
DYRENIUM CAP	-	B
amiloride tab (MIDAMOR equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
DIURETICS Cont.		
spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 or older)	PA	G
spironolactone tab (ALDACTONE equiv)	-	G
triamterene cap (DYRENIUM equiv)	-	NC
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
DIURIL SUSP	-	B
CHLOROTHIAZIDE TAB	-	G
chlorothiazide tab (DIURIL equiv)	-	G
chlorthalidone tab	-	G
hydrochlorothiazide cap (MICROZIDE equiv)	-	G
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	G
indapamide tab (LOZOL equiv)	-	G
metolazone tab (ZAROXOLYN equiv)	-	G
THALITONE TAB	-	NC
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ADRENAL STEROID INHIBITORS		
ISTURISA TAB 10MG (QL= 6 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
ISTURISA TAB 1MG (QL= 8 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
ISTURISA TAB 5MG (QL= 2 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
RECORLEV TAB	-	NC
BONE DENSITY REGULATORS		
ALENDRONATE TAB 40MG	-	B
FORTICAL NASAL SPRAY	-	B
NATPARA INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B
PROLIA INJ (QL= 1 fill/6 months)	LMSP-QL	B
TERIPARATIDE INJ 620MCG/2.48ML	LMSP	B
TYMLOS INJ	LMSP	B
XGEVA INJ	MSP	B
alendronate sodium oral soln (FOSAMAX equiv)	-	G
alendronate tab (FOSAMAX equiv)	-	G
calcitonin nasal spray (MIACALCIN equiv)	-	G
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	G
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	G
risedronate tab (ACTONEL equiv)	-	G
BINOSTO TAB	-	NC
calcitonin inj (MIACALCIN equiv)	-	NC
FORTEO INJ	-	NC
FOSAMAX+D TAB	-	NC
teriparatide (recombinant) soln pen-inj 600mcg/2.4ml (FORTEO equiv)	-	NC
CORTICOTROPIN		
ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
CORTROPHIN INJ GEL	-	NC
FERTILITY REGULATORS		
CLOMID TAB	INF	B
CLOMIPHENE TAB	INF	B
OVIDREL INJ	INF-MSP	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.

GNRH/LHRH ANTAGONISTS

cetorelix acetate for inj kit (CETROTIDE equiv)	INF-MSP	B
CETROTIDE KIT	INF-MSP	B
ganirelix ac inj (GANIRELIX equiv)	INF-MSP	B
ORLISSA TAB 150MG (QL= 1 tab/day)	PA-QL	B
ORLISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	B

GROWTH HORMONE RECEPTOR ANTAGONISTS

SOMAVERT INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B
--	-------	---

GROWTH HORMONE RELEASING HORMONES (GHRH)

EGRIFTA INJ	-	EXC
-------------	---	-----

GROWTH HORMONES

GENOTROPIN INJ	LMSP-PA	B
OMNITROPE INJ	LMSP-PA	B
SKYTROFA INJ	LMSP-PA	B
HUMATROPE INJ, ZOMACTON INJ	-	NC
NGENLA INJ	-	NC
NORDITROPIN INJ, NUTROPIN AQ INJ	-	NC
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC
SOGROYA INJ	-	NC
ZOMACTON INJ	-	NC

HORMONE RECEPTOR MODULATORS

raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
OSPHENA TAB	-	NC

INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)

INCRELEX INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD	B
--	----	---

LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS

LUPRON DEPOT PED INJ	MSP	B
LUPRON DEPOT-PED INJ	MSP	B
SUPPRELIN LA INJ	MSP-PA	B
SYNAREL NASAL SOLN	-	B

MENOPAUSAL SYMPTOMS SUPPRESSANTS

VEOZAH TAB (QL= 1 tab/day)	PA-QL	B
----------------------------	-------	---

METABOLIC MODIFIERS

ALDURAZYME INJ	MSP-PA	B
betaine powder for oral solution (CYSTADANE equiv) (Only available through Walgreens 888-347-3416)	LD	B
CALCITRIOL INJ	LMSP	B
CYSTADANE POWDER	MSP-PA	B
ELAPRASE INJ	MSP-PA	B
FABRAZYME INJ	MSP-PA	B
GALAFOLD CAP (QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
LUMIZYME/MYOZYME INJ	MSP-PA	B
NAGLAZYME INJ	MSP-PA	B
PALYNZIQ INJ (QL= 1 inj/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523)	LD	B
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
XPHOZAH TAB (QL= 2 tabs/day)	PA-QL	B
calcitriol cap (ROCALTROL equiv)	-	G
calcitriol soln (ROCALTROL equiv)	-	G
carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007)	LD-PA	G
cinacalcet tab (SENSIPAR equiv)	-	G
doxercalciferol cap (HECTOROL equiv)	-	G
levocarnitine soln (CARNITOR equiv)	-	G
levocarnitine tab (CARNITOR equiv)	-	G
paricalcitol cap (ZEMPLAR equiv)	-	G
sapropterin dihydrochloride powder packet (KUVAN equiv)	LMSP-PA	G
sapropterin dihydrochloride soluble tab (KUVAN equiv)	LMSP-PA	G
sodium phenylbutyrate powder (BUPHENYL equiv)	-	G
sodium phenylbutyrate tab (BUPHENYL equiv)	-	G
CARBAGLU TAB	-	NC
CITRULLINE EASY TAB	-	NC
CYSTADANE POWDER	-	NC
KUVAN POWDER PACK	-	NC
KUVAN TAB	-	NC
MYALEPT INJ	-	NC
nitisinone cap (ORFADIN equiv)	-	NC
NITYR TAB	-	NC
OLPRUVA PACK	-	NC
OPFOLDA CAP	-	NC
ORFADIN CAP	-	NC
ORFADIN SUSP	-	NC
RAVICTI LIQUID	-	NC
RAYALDEE CAP	-	NC
SENSIPAR TAB	-	NC
XURIDEN POWDER	-	NC
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB (QL= 1 tab/day)	PA-QL	B
NATRIURETIC PEPTIDES		
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	B
POSTERIOR PITUITARY HORMONES		
DDAVP NASAL SOLN	-	B
STIMATE NASAL SOLN	-	B
desmopressin acetate nasal spray (DDAVP equiv)	-	G
desmopressin acetate tab (DDAVP equiv)	-	G
DDAVP INJ	-	NC
NOCDURNA SL TAB	-	NC
NOCTIVA EMULSION SPRAY	-	NC
PROGESTERONE RECEPTOR ANTAGONISTS		
mifepristone tab (MIFIPREX equiv)	-	G
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.

SOMATOSTATIC AGENTS

OCTREOTIDE INJ 100MCG	LMSP	B
SIGNIFOR INJ (QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
octreotide inj (SANDOSTATIN equiv)	LMSP	G
BYNFEZIA PEN INJ	-	NC
MYCAPSSA CAP	-	NC
SANDOSTATIN LAR INJ KIT	-	NC

VASOPRESSIN RECEPTOR ANTAGONISTS

JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
JYNARQUE TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
TOLVAPTAN TAB	-	NC
tolvaptan tab (SAMSCA equiv)	-	NC

ESTROGENS

ESTROGEN COMBINATIONS

DUAVEE TAB	-	B
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	B
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	B
PREFEST TAB	-	B
PREMPHASE TAB, PREMPRO TAB	-	B
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	G
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	G
jinteli tab (FEMHRT equiv)	-	G
ANGELIQ TAB	-	NC
BIJUVA CAP	-	NC
CLIMARA PRO PATCH	-	NC
COMBIPATCH	-	NC
FEMHRT TAB	-	NC

ESTROGENS

MENEST TAB	-	B
PREMARIN TAB	-	B
DEPO-ESTRADIOL INJ	-	G
estradiol patch (CLIMARA equiv)	-	G
estradiol patch (VIVELLE-DOT equiv)	-	G
estradiol tab (ESTRACE equiv)	-	G
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	G
ALORA PATCH	-	NC
CLIMARA PATCH	-	NC
DELESTROGEN INJ	-	NC
DIVIGEL GEL	-	NC
DIVIGEL GEL, ELESTRIN GEL	-	NC
estradiol td gel (DIVIGEL equiv)	-	NC
EVAMIST SPRAY	-	NC
MENOSTAR PATCH	-	NC
VIVELLE-DOT PATCH	-	NC

FLUOROQUINOLONES

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
FLUOROQUINOLONES		
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	B
CIPRO SUSP	-	B
CIPROFLOXACIN 100MG TAB	-	B
ciprofloxacin susp (CIPRO equiv)	-	G
ciprofloxacin tab (CIPRO equiv)	-	G
levofloxacin soln (LEVAQUIN equiv)	-	G
LEVOFLOXACIN SOLN 25MG/ML	-	G
levofloxacin tab (LEVAQUIN equiv)	-	G
moxifloxacin tab (AVELOX equiv)	-	G
ofloxacin tab (FLOXIN equiv)	-	G
FACTIVE TAB	-	NC
PROQUIN XR TAB	-	NC
GASTROINTESTINAL AGENTS - MISC.		
5-HT4 RECEPTOR AGONISTS		
MOTEGRITY TAB (QL= 1 tab/day)	PA-QL	B
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB (QL= 1 tab/day)	PA-QL	B
BILE ACID SYNTHESIS DISORDER AGENTS		
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	B
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL-SF-¢	B
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	G
ursodiol tab (URSO (FORTE) equiv)	-	G
RELTONE CAP	-	NC
URSODIOL CAP	-	NC
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	G
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	PA-QL	G
AMITIZA CAP	-	NC
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	G
metoclopramide tab (REGLAN equiv)	-	G
GIMOTI NASAL SPRAY	-	NC
METZOZOLV ODT	-	NC
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS		
BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481)	LD-PA-QL	B
INFLAMMATORY BOWEL AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
AVSOLA INJ	MSP-PA	B
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	LMSP-PA-QL	B
DIPENTUM CAP	-	B
RENFLIXIS INJ	MSP-PA	B
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	LMSP-PA-QL	B
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	LMSP-PA-QL	B
balsalazide cap (COLAZAL equiv)	-	G
mesalamine DR tab (LIALDA equiv)	-	G
mesalamine enema (ROWASA equiv)	-	G
mesalamine enema kit (ROWASA equiv)	-	G
mesalamine ER cap (APRISO equiv)	-	G
mesalamine supp (CANASA equiv)	-	G
sulfasalazine EC tab (AZULFIDINE equiv)	-	G
sulfasalazine tab (AZULFIDINE equiv)	-	G
APRISO CAP	-	NC
ASACOL HD TAB	-	NC
ASACOL HD TAB, MESALAMINE TAB	-	NC
CIMZIA INJ	-	NC
DELZICOL CAP	-	NC
ENTYVIO INJ	-	NC
LIALDA TAB	-	NC
mesalamine DR cap (DELZICOL equiv)	-	NC
mesalamine ER cap (PENTASA CR equiv)	-	NC
mesalamine tab (ASACOL equiv)	-	NC
MESALAMINE TAB DR	-	NC
OMVOH INJ	-	NC
PENTASA CR CAP	-	NC
PENTASA CR CAP 250MG	-	NC
REMICADE INJ	-	NC
ROWASA KIT	-	NC
VELSIPITY TAB	-	NC

INTESTINAL ACIDIFIERS

lactulose soln	-	G
----------------	---	---

IRRITABLE BOWEL SYNDROME (IBS) AGENTS

LINZESS CAP (QL= 1 cap/day)	PA-QL	B
alosetron tab (LOTRONEX equiv)	-	G
IBSRELA TAB	-	NC
VIBERZI TAB	-	NC
ZELNORM TAB	-	NC

LIVE FECAL MICROBIOTA

VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	B
--	----------	---

PERIPHERAL OPIOID RECEPTOR ANTAGONISTS

MOVANTIK TAB	PA	B
SYMPROIC TAB	PA	B
alvimopan cap (ENTEREG equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
ENTEREG CAP	-	NC
RELISTOR INJ	-	NC
RELISTOR INJ KIT	-	NC
RELISTOR TAB	-	NC
PHOSPHATE BINDER AGENTS		
AURYXIA TAB (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B
FOSRENOL CHEW TAB	-	B
FOSRENOL POWDER PACK	-	B
PHOSLYRA SOLN	-	B
REVELA TAB	-	B
calcium acetate cap (PHOSLO equiv)	-	G
lanthanum carbonate chew tab (FOSRENOL equiv)	-	G
sevelamer powder pak (REVELA equiv)	-	G
sevelamer tab (REVELA TAB equiv)	-	G
RENAGEL TAB 800MG	-	NC
sevelamer hydrochloride tab (RENAGEL equiv)	-	NC
VELPHORO CHEW TAB	-	NC
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT	-	NC
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB	-	NC

GENERAL ANESTHETICS

ANESTHETICS - MISC.		
KETAMINE HCL TROCHES	-	NC

GENITOURINARY AGENTS - MISCELLANEOUS

ALKALINIZERS		
CYTRA K CRYSTALS	-	G
CYTRA-3 SYRUP	-	G
ORACIT SOLN	-	G
potassium citrate CR tab (UROKIT-K TAB equiv)	-	G
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	G
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	G
sodium citrate/citric acid soln (BICITRA equiv)	-	G
tricitrates soln (POLYCITRA-LC equiv)	-	G

CYSTINOSIS AGENTS		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	B
PROCYSBI CAP	-	NC
PROCYSBI GRANULES PACKET	-	NC

HYPEROXALURIA AGENTS		
RIVFLOZA INJ	-	NC

IGA NEPHROPATHY (IGAN) AGENTS		
FILSPARI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B

INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	OTC	Limited Distribution
PA	Plan Exclusion	MSP	RDX	Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	SMKG	Restricted to Diagnosis
ST	Prior Authorization	SF	¢	Smoking Cessation
	Restricted to Specialist	VAC		RxCENTS
	Step Therapy			

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

GENITOURINARY AGENTS - MISCELLANEOUS Cont.

PENTOSAN CAP	-	NC
--------------	---	----

PROSTATIC HYPERTROPHY AGENTS

alfuzosin SR tab (UROXATRAL equiv)	-	G
dutasteride cap (AVODART equiv)	-	G
finasteride tab (PROSCAR equiv)	-	G
silodosin cap (RAPAFLO equiv)	-	G
tamsulosin cap (FLOMAX equiv)	-	G
CARDURA XL TAB	-	NC
dutasteride/tamsulosin cap (JALYN equiv)	-	NC
ENTADFI CAP	-	NC

URINARY ANALGESICS

phenazopyridine tab 95mg (AZO equiv)	OTC	EXC
phenazopyridine tab 97.5mg (AZO equiv)	OTC	EXC
phenazopyridine tab 99.5mg (AZO equiv)	OTC	EXC
phenazopyridine tab (PYRIDIUM equiv)	-	NC
PYRIDIUM TAB	-	NC

URINARY STONE AGENTS

LITHOSTAT TAB	-	B
tiopronin tab (THIOLA equiv)	LMSP-PA	G
THIOLA EC TAB	-	NC

GOUT AGENTS

GOUT AGENT COMBINATIONS

colchicine/probenecid tab (COL-BENEMID equiv)	-	G
DUZALLO TAB	-	NC

GOUT AGENTS

GLOPERBA SOLN (Prior Authorization required for members age 9 or older)	PA	B
allopurinol tab (ZYLOPRIM equiv)	-	G
colchicine tab (COLCRYS equiv)	-	G
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST-¢	G
ALLOPURINOL TAB	-	NC
colchicine cap (MITIGARE equiv)	-	NC
COLCRYS TAB	-	NC
ULORIC TAB	-	NC
ZURAMPIC TAB	-	NC

URICOSURICS

probenecid tab (BENEMID equiv)	-	G
--------------------------------	---	---

HEMATOLOGICAL AGENTS - MISC.

ANTHEMOPHILIC PRODUCTS

ADVATE INJ	MSP-PA	B
ALPHANATE/HEMOFIL/KOATE INJ	MSP-PA	B
ALPHANINE SD/MONONINE INJ	MSP-PA	B
BEBULIN/PROFILNINE INJ	MSP-PA	B
BENEFIX INJ	MSP-PA	B
BENEFIX/RIXUBIS INJ	MSP-PA	B
FEIBA INJ	MSP-PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	generic = small letters Infertility	LD	BRANDS = CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
HELIXATE/KOGENATE INJ	MSP-PA	B
HEMLIBRA INJ	LMSP-PA	B
HUMATE-P/WILATE INJ	MSP-PA	B
MONOCLATE-P INJ	MSP-PA	B
NOVOSEVEN INJ	MSP-PA	B
RECOMBIMATE INJ	MSP-PA	B
RIASTAP INJ	MSP-PA	B
XYNTHA INJ	MSP-PA	B
AFSTYLA KIT	-	NC
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant inj (FIRAZYR equiv)	LMSP-PA	G
FIRAZYR INJ	-	NC
COMPLEMENT INHIBITORS		
BERINERT INJ (Only available through Accredo 800-803-2523)	LD-PA	B
CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
HAEGARDA INJ (Only available through Accredo 800-803-2523)	LD-PA	B
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	B
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
FABHALTA CAP	-	NC
ZILBRYSQ INJ	-	NC
HEMATOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	G
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
ORLADEYO CAP	-	NC
PLATELET AGGREGATION INHIBITORS		
BRILINTA TAB	-	B
CABLIVI INJ KIT (QL= 1 vial/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	B
anagrelide cap (AGRYLIN equiv)	-	G
aspirin/dipyridamole cap (AGGRENOX equiv)	-	G
cilostazol tab (PLETAL equiv)	-	G
clopidogrel tab 75mg (PLAVIX equiv)	-	G
dipyridamole tab (PERSANTINE equiv)	-	G
prasugrel tab (EFFIENT equiv)	-	G
AGGRENOX CAP	-	NC
ASPIRIN/OMEPRAZOLE ER TAB	-	NC
CLOPIDOGREL THERAPY PACK	-	NC
PLAVIX TAB 300MG	-	NC
YOSPRALA TAB	-	NC
PYRUVATE KINASE ACTIVATORS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

HEMATOLOGICAL AGENTS - MISC. Cont.

PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B

HEMATOPOIETIC AGENTS

AGENTS FOR GAUCHER DISEASE

CEREZYME INJ	MSP-PA	B
VPRIV INJ	MSP-PA	B
miglustat cap (ZAVESCA equiv) (Only available through Accredo 800-803-2523)	LD-PA	G
CERDELGA CAP	-	NC
ZAVESCA CAP	-	NC

AGENTS FOR SICKLE CELL ANEMIA

DROXIA CAP	-	B
SIKLOS TAB	-	NC

AGENTS FOR SICKLE CELL DISEASE

ENDARI POWDER PACK (QL= 6 packets/day)	LMSP-PA-QL	B
OXBRYTA TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
OXBRYTA TAB FOR ORAL SUSP (QL= 5 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B

COBALAMINS

cyanocobalamin inj	-	G
cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv)	-	NC
NASCOBAL SPRAY	-	NC

FOLIC ACID/FOLATES

folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0
folic acid tab 400mcg (Covered for females only)	OTC	\$0
folic acid tab 800mcg (Covered for females only)	OTC	\$0

HEMATOPOIETIC GROWTH FACTORS

DOPTELET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
FULPHILA INJ	LMSP	B
NIVESTYM INJ	LMSP	B
NPLATE INJ	MSP-PA	B
NYVEPRIA INJ	LMSP	B
PROMACTA POWDER	LMSP-PA	B
PROMACTA TAB	LMSP-PA	B
RETACRIT INJ	LMSP	B
ZARXIO INJ	LMSP	B
ALVAIZ TAB	-	NC
ARANESP INJ	-	NC
EPOGEN INJ	-	NC
FYLNETRA INJ	-	NC
GRANIX INJ	-	NC
JESDUVROQ TAB	-	NC
LEUKINE INJ	-	NC
MIRCERA INJ	-	NC
MULPLETA TAB	-	NC
NEULASTA INJ	-	NC
NEUPOGEN INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
PROCRIT INJ	-	NC
REBLOZYL INJ	-	NC
RELEUKO INJ	-	NC
RELEUKO PREFILLED SYRINGE INJ	-	NC
STIMUFEND INJ	-	NC
UDENYCA INJ	-	NC
ZIEXTENZO INJ	-	NC
HEMATOPOIETIC MIXTURES		
NEPHRON FA TAB	-	B
ferrex 150 forte cap	-	G
folbee tab	-	G
MULTIGEN FOLIC TAB	-	G
MULTIGEN PLUS TAB	-	G
MULTIGEN TAB	-	G
tricon cap (TRINSICON equiv)	-	G
BENTIVITE TAB	-	NC
BIFERARX TAB	-	NC
B-SERENE PAD	-	NC
CYFOLEX CAP	-	NC
FEONYX TAB	-	NC
FERRO-PLEX TAB	-	NC
FOLITE TAB	-	NC
folvite-d tab (GENICIN VITA-D equiv)	-	NC
FOLVITE-FE TAB	-	NC
OVEEZA CAP	-	NC
PUREFOLIX TAB	-	NC
IRON		
ACCRUFER CAP	-	NC
ferrous sulfate elixir	OTC	NC
FERROUS SULFATE LIQUID	OTC	NC
ferrous sulfate soln	OTC	NC
STEM CELL MOBILIZERS		
MOZOBIL INJ	MSP-PA	B
plerixafor subcutaneous inj (MOZOBIL INJ equiv)	MSP-PA	B
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid soln (AMICAR equiv)	-	G
aminocaproic acid tab (AMICAR equiv)	-	G
tranexamic acid tab (LYSTEDA equiv)	-	G
HYPNOTICS		
NON-BARBITURATE HYPNOTICS		
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	G
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB	-	NC
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	LD
PA	Plan Exclusion	MSP	Limited Distribution
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	Over-the-Counter
ST	Prior Authorization	SF	Restricted to Diagnosis
	Restricted to Specialist	VAC	Smoking Cessation
	Step Therapy		RxCENTS
			¢

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
ANTIHISTAMINE HYPNOTICS		
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	G
BARBITURATE HYPNOTICS		
BUTISOL TAB	-	B
SECONAL CAP	-	B
phenobarbital elixir	-	G
phenobarbital tab	-	G
HYPNOTICS - TRICYCLIC AGENTS		
doxepin tab (SILENOR equiv)	-	NC
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	G
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	G
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	G
temazepam cap 15mg (RESTORIL equiv)	-	G
temazepam cap 22.5mg (RESTORIL equiv)	-	G
temazepam cap 30mg (RESTORIL equiv)	-	G
temazepam cap 7.5mg (RESTORIL equiv)	-	G
triazolam tab (HALCION equiv)	-	G
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	G
AMBIEN CR TAB	-	NC
DORAL TAB	-	NC
EDLUAR SL TAB	-	NC
FLURAZEPAM CAP	-	NC
INTERMEZZO SL TAB	-	NC
ZOLPIDEM CAP	-	NC
zolpidem ER tab (AMBIEN CR equiv)	-	NC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC
ZOLPIDEM TARTRATE SL TAB 1.75MG	-	NC
ZOLPIDEM TARTRATE SL TAB 3.5MG	-	NC
ZOLPIMIST SPRAY	-	NC
OREXIN RECEPTOR ANTAGONISTS		
DAYVIGO TAB	-	NC
QUVIVIQ TAB	-	NC
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	PA-QL	G
HETLIOZ CAP	-	NC
HETLIOZ SUSP	-	NC
ROZEREM TAB	-	NC
tasimelteon cap (HETLIOZ equiv)	-	NC
LAXATIVES		
LAXATIVE COMBINATIONS		
GAVILYTE-C SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
GOLYTELY SOLN (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	MSP	RDX	Over-the-Counter
RS	Prior Authorization	QL	SMKG	Restricted to Diagnosis
ST	Restricted to Specialist	SF	¢	Smoking Cessation
	Step Therapy	VAC		RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
LAXATIVES Cont.		
NULYTELY SOLN (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
peg 3350/electrolytes soln (NULYTELY equiv) (Covered at \$0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0
sodium/magnesium/potassium soln (SUPREP equiv) (QL= 2 fills/calendar year; \$0 for members 45-75 years, all other members covered at generic copay)	QL	\$0
MOVIPREP SOLN (Step Therapy requires trial of CLENPIQ)	ST	B
PEG-PREP KIT	PA	B
SUFLAVE SOLN (QL= 2 fills/calendar year)	QL	B
CLENPIQ SOLN	-	NC
PLENVU SOLN	-	NC
SUPREP BOWEL PREP PACK	-	NC
SUTAB TAB	-	NC
LAXATIVES - MISCELLANEOUS		
MIRALAX PACKET	OTC	EXC
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	EXC
lactulose soln	-	G
GIALAX KIT	-	NC
KRISTALOSE PACK, LACTULOSE PACK	-	NC
KRISTALOSE PACKET	-	NC
SALINE LAXATIVES		
OSMOPREP TAB	-	NC

LOCAL ANESTHETICS-PARENTERAL

LOCAL ANESTHETIC COMBINATIONS

ROPIVICAINE/CLONIDINE/KETOROLAC INJ	-	NC
-------------------------------------	---	----

MACROLIDES

AZITHROMYCIN

ZITHROMAX POWDER PACK	-	B
azithromycin susp (ZITHROMAX equiv)	-	G
azithromycin tab (ZITHROMAX equiv)	-	G

CLARITHROMYCIN

CLARITHROMYC SUSP	-	B
clarithromycin tab (BIAXIN equiv)	-	G
clarithromycin ER tab (BIAXIN XL equiv)	-	NC

ERYTHROMYCINS

ERYTHROMYCIN EC CAP (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	B
erythromycin DR cap (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	G
erythromycin ethylsuccinate susp (ERYPED equiv) (Step Therapy requires trial of azithromycin or clarithromycin)	ST	G
erythromycin tab (ERY-TAB equiv) (Step Therapy requires trial of azithromycin, clarithromycin or doxycycline hyclate 100mg)	ST	G
erythromycin tab (ERYTHROMYCIN equiv) (Step Therapy require trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MACROLIDES Cont.		
ERYPED SUSP	-	NC
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	NC
FIDAXOMICIN		
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	B
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN)	QL-ST	B

MEDICAL DEVICES AND SUPPLIES

CONTRACEPTIVES		
CERVICAL CAP	-	\$0
DIAPHRAGM	-	\$0
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$0
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	\$0
DIABETIC SUPPLIES		
ONETOUCH KIT	OTC	\$0
ONETOUCH METER	OTC	\$0
ONETOUCH VERIO FLEX METER	OTC	\$0
ONETOUCH VERIO METER	OTC	\$0
ONETOUCH VERIO REFLECT METER	OTC	\$0
ACCU-CHEK AVIVA PLUS METER	OTC-PA	B
ACCU-CHEK GUIDE CARE METER	OTC-PA	B
ACCU-CHEK GUIDE ME KIT	OTC-PA	B
ACCU-CHEK NANO METER	OTC-PA	B
DIABETIC METER (all other diabetic meters)	OTC-PA	B
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	B
OMNIPOD 5 G7 MIS PODS (QL= 10 pods/30 days)	QL	B
OMNIPOD 5 INTRO KIT (QL= 1 kit/year)	QL	B
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	B
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	B
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	B
OMNIPOD GO KIT (QL= 10 pods/month)	QL	B
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	B
V-GO INJ KIT (QL= 1 kit/day)	QL	B
CALIBRATION LIQUID	OTC	G
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G6 SENSOR (QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	OTC	Limited Distribution
PA	Plan Exclusion	MSP	RDX	Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	SMKG	Restricted to Diagnosis
ST	Prior Authorization	SF	¢	Smoking Cessation
	Restricted to Specialist	VAC		RxCENTS
	Step Therapy			

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 3 READER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
LANCET KIT	OTC	G
LANCETS	OTC	G
ONETOUCH DELICA LANCETS	OTC	G
ONETOUCH DELICA PLUS LANCETS	OTC	G
ONETOUCH DELICA ULTRASOFT LANCETS	OTC	G
FREESTYLE FREEDOM LITE METER	OTC	NC
FREESTYLE INSULINX METER	OTC	NC
FREESTYLE LITE METER	OTC	NC
FREESTYLE PRECISION NEO METER	OTC	NC
OMNIPOD DASH PDM KIT	-	NC
PRECISION XTRA METER	-	NC
MISC. DEVICES		
ALCOHOL SWABS	OTC	NC
ORAL HYGIENE PRODUCTS		
HURRISEAL MIS SNAP	-	NC
PARENTERAL THERAPY SUPPLIES		
NOVOPEN ECHO	-	B
B-D INSULIN SYRINGE	--OTC	G
B-D PEN NEEDLE	OTC	G
CARETOUCH MIS	OTC	G
NOVOFINE PEN NEEDLE	OTC	G
NOVOTWIST PEN NEEDLE	OTC	G
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	G
CEQR SIMPLICITY	-	NC
INPEN INSULIN INJECTION DEVICE	-	NC
INSULIN SYRINGE	OTC	NC
PEN NEEDLE	OTC	NC
RESPIRATORY THERAPY SUPPLIES		
AEROCHAMBER	OTC	B
PEAK FLOW METER	OTC	G
MIGRAINE PRODUCTS		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	B
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	B
NURTEC ODT	-	NC
QULIPTA TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	generic = small letters	LD	BRANDS = CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	INF	OTC	Over-the-Counter
PA	Prior Authorization	MSP	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	QL	SMKG	Smoking Cessation
ST	Step Therapy	SF	¢	RxCENTS
		VAC		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
MIGRAINE COMBINATIONS		
ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	B
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	G
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC
ergotamine/caffeine tab (CAFERGOT equiv)	-	NC
MIGERGOT SUPP	-	NC
PRODRIN TAB	-	NC
SUMANSETRON PAK	-	NC
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC
TREXIMET TAB	-	NC
MIGRAINE PRODUCTS		
dihydroergotamine mesylate nasal spray (MIGRANAL equiv) (QL= 8 sprays/fill, 2 fills/30 days)	PA-QL	G
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC
TRUDHESA NASAL SPRAY	-	NC
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES		
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	B
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	B
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	B
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year)	PA-QL	B
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POWDER	-	NC
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	NC
ELYXYB SOLN	-	NC
SEROTONIN AGONISTS		
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	B
REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	B
ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B
ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G
SUMATRIPTAN INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	G
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	G
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	G
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	G
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	G
zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	G
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	PA-QL	G
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	PA-QL	G
almotriptan tab (AXERT equiv)	-	NC
ALSUMA INJ, ZEMBRACE SYMTOUCH INJ	-	NC
AMERGE TAB	-	NC
AXERT TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
eletriptan tab (RELPAE equiv)	-	NC
FROVA TAB	-	NC
frovatriptan tab (FROVA equiv)	-	NC
IMITREX NASAL SPRAY, SUMATRIPTAN NASAL SPRAY	-	NC
IMITREX TAB	-	NC
MAXALT MLT TAB	-	NC
MAXALT TAB	-	NC
ONZETRA XSAIL	-	NC
RELPAE TAB	-	NC
SUMAVEL DOSEPRO INJ	-	NC
TOSYMRA SOLN	-	NC
ZECUITY PAD	-	NC
ZOMIG TAB	-	NC

MINERALS & ELECTROLYTES

FLUORIDE

FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
sodium fluoride chew tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0

PHOSPHATE

K-PHOS TAB	-	B
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	G
potassium phosphate monobasic tab (K-PHOS equiv)	-	G

POTASSIUM

K-TAB	-	G
POT/CHLORIDE EFFER TAB	-	G
potassium bicarbonate effer tab (K-LYTE equiv)	-	G
potassium chloride effer tab (K-LYTE/CL equiv)	-	G
potassium chloride ER cap (MICRO-K equiv)	-	G
potassium chloride ER tab (K-TAB equiv)	-	G
potassium chloride micro tab (K-DUR equiv)	-	G
potassium chloride powder packet (KLOR-CON equiv)	-	G
potassium chloride soln	-	G
POTASSIUM CHLORIDE TAB ER	-	G
POKONZA POWDER	-	NC

ZINC

GALZIN CAP	-	B
------------	---	---

MISCELLANEOUS THERAPEUTIC CLASSES

CHELATING AGENTS

penicillamine tab (DEPEN TITRATAB equiv)	-	G
trientine cap (SYPRINE equiv)	LMSP-PA	G
CUVRIOR TAB	-	NC
penicillamine cap (CUPRIMINE equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MISCELLANEOUS THERAPEUTIC CLASSES Cont.		
TRIENTINE CAP	-	NC
IMMUNOMODULATORS		
JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
REVLIMID CAP (QL= 1 cap/day; Only available through Walgreens 888-347-3416; Restricted to Oncology or Hematology Specialist)	LD-QL-RS	B
REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	B
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	G
IMMUNOSUPPRESSIVE AGENTS		
ENSPRYNG INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
everolimus tab (ZORTRESS equiv)	PA	G
sirolimus soln (RAPAMUNE equiv)	-	G
ASTAGRAF XL CAP	-	NC
azathioprine tab 100mg (AZASAN equiv)	-	NC
azathioprine tab 75mg (AZASAN equiv)	-	NC
PROGRAF PACKET	-	NC
PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS		
VIJOICE TAB (QL= 1 tab/day)	MSP-PA-QL	B
VIJOICE TAB 250MG (QL= 2 tabs/day)	MSP-PA-QL	B
POTASSIUM REMOVING AGENTS		
LOKELMA PAK	PA	B
SPS SUSP	-	G
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	LMSP-PA-QL	B
BENLYSTA INJ (QL= 4 inj/28 day)	LMSP-PA-QL	B
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
FIRST MOUTHWASH BLM	-	B
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	G
LIDOCAINE ORAL SOLN 4%	-	NC
ANTI-INFECTIVES - THROAT		
ORAVIG TAB	-	B
clotrimazole troches (MYCELEX TROCHES equiv)	-	G
nystatin susp	-	G
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	G
DENTAL PRODUCTS		
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
PREVIDENT PASTE	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
PREVIDENT SOLN	-	B
FLUORIDEX SENSITIVITY PASTE	-	G
sodium fluoride gel (PREVIDENT equiv)	-	G
sodium fluoride paste (PREVIDENT equiv)	-	G
sodium fluoride rinse (PREVIDENT equiv)	-	G
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	G
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	G
THROAT PRODUCTS - MISC.		
GELCLAIR GEL	-	B
cevimeline cap (EVOXAC equiv)	-	G
pilocarpine tab (SALAGEN equiv)	-	G
PROTHELIAL PASTE	-	NC
SILATRIX GEL	-	NC
MULTIVITAMINS		
B-COMPLEX VITAMINS		
EB-N3 DR CAP	-	NC
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	G
dialyvite tab (NEPHRO-VITE equiv)	-	G
DIALYVITE/ZINC TAB	-	G
FOLBEE PLUS CZ TAB	-	G
renaphro cap (NEPHROCAP equiv)	-	G
FIBRIK CAP	-	NC
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	G
v-c forte cap (V-C FORTE equiv)	-	G
DEXATRAN CAP	-	NC
FOLAGENT DHA CAP	-	NC
FOLAMED DHA CAP	-	NC
REMEDIENT CAP	-	NC
VITRECYL IRON TAB	-	NC
VITRECYL TAB	-	NC
MULTIVITAMINS		
FOLIKA-V TAB	-	NC
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	G
POLY-VI-FLOR CHEW W/IRON	-	NC
PED MV W/ FLUORIDE		
FLORIVA PLUS DROPS	-	B
QUFLORA PEDIATRIC CHEW TAB	-	B
MULTIVITAMIN/FLUORIDE CHEW 0.25MG	-	G
MULTIVITAMIN/FLUORIDE CHEW 1MG	-	G
MULTIVITAMIN/FLUORIDE CHEW TAB	-	G
pediatric multiple vitamins/fluoride chew tab	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
pediatric multiple vitamins/fluoride soln	-	G
POLY-VI-FLOR CHEW 0.25MG	-	NC
POLY-VI-FLOR CHEW 0.5MG	-	NC
POLY-VI-FLOR CHEW 1MG	-	NC
POLY-VI-FLOR SUSP	-	NC
PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE		
FLORIVA CHEW TAB	-	NC
PRENATAL VITAMINS		
NEONATAL 19 TAB	-	B
NEONATAL FE TAB	-	B
PRENATAL VITAMINS (NON-PREFERRED)	-	B
VITAFOL STRIPS	-	B
COMPLETE NATAL DHA	-	G
CONCEPT DHA CAP	-	G
PRENATA	-	G
PRENATABS RX TAB	-	G
PRENATAL 19 CHEW TAB	-	G
PRENATAL 19 TAB	-	G
PRENATAL FORMULA, PRENATAL MULTI + DHA	-	G
PRENATAL MULTIVITAMIN + D	-	G
PRENATAL PLUS IRON	-	G
VINATE II	-	G
VINATE M	-	G
VP-PNV-DHA CAP	-	G
ACTIVE OB	-	NC
AZESCHEW TAB	-	NC
AZESCO TAB	-	NC
CITRANATAL 90 DHA, CITRANATAL ASSURE	-	NC
CITRANATAL B CALM	-	NC
CITRANATAL BLOOM	-	NC
CITRANATAL CAP MEDLEY	-	NC
CITRANATAL HARMONY	-	NC
CITRANATAL RX	-	NC
DUET	-	NC
DUET DHA 400, DUET DHA BALANCED	-	NC
ENBRACE HR	-	NC
FOLET ONE	-	NC
JENLIVA CAP	-	NC
MULTI-MAC TAB	-	NC
MYNATAL-Z TAB	-	NC
NATACHEW	-	NC
NEEVO DHA	-	NC
NESTABS ABC	-	NC
NESTABS DHA	-	NC
NESTABS ONE	-	NC
NEXA PLUS	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
OB COMPLETE ONE	-	NC
OB COMPLETE PETITE	-	NC
OB COMPLETE PREMIER	-	NC
PREFERA OB	-	NC
PREFERA OB ONE	-	NC
PREGEN DHA CAP	-	NC
PREGENNA TAB	-	NC
PRENA1 CHEW	-	NC
PRENA1 PEARL, VITAPEARL	-	NC
PRENA1 TRUE, VITATRUE	-	NC
PRENARA CAP	-	NC
PRENATE AM	-	NC
PRENATE CHEWABLE	-	NC
PRENATE DHA	-	NC
PRENATE ELITE	-	NC
PRENATE ESSENTIAL	-	NC
PRENATE MINI	-	NC
PRENATE MINI, TRISTART DHA	-	NC
PRENATE TAB	-	NC
PRENATRIX TAB	-	NC
PRENATRYL TAB	-	NC
PRIMACARE	-	NC
PROVIDA DHA	-	NC
PROVIDA OB	-	NC
SELECT OB + DHA	-	NC
THRIVITE RX	-	NC
VITAFOL GUMMIES	-	NC
VITAFOL OB	-	NC
VITAFOL ULTRA	-	NC
VITAFOL-OB + DHA	-	NC
VITAFOL-ONE, VITAFOL FE+	-	NC

MUSCULOSKELETAL THERAPY AGENTS

CENTRAL MUSCLE RELAXANTS

BACLOFEN ORAL SOLN 10 MG/5ML (Prior Authorization Required for members age 9 and older)	PA	B
BACLOFEN ORAL SOLN 5 MG/5ML (Prior Authorization Required for members age 9 and older)	PA	B
BACLOFEN SUSP (Prior Authorization Required for members age 9 or older)	PA	B
FLEQSUVY SUSP (Prior Authorization required for members age 9 or older)	PA	B
LYVISPAN GRANULE PACKET (Members age 9 or older require Prior Authorization)	PA	B
baclofen susp (BACLOFEN equiv) (Prior Authorization Required for members age 9 or older)	PA	G
baclofen tab (BACLOFEN equiv)	-	G
carisoprodol tab (SOMA equiv) (QL= 90 tabs/90 days)	QL	G
chlorzoxazone tab 500mg	-	G
cyclobenzaprine tab (FLEXERIL equiv)	-	G
methocarbamol tab (ROBAXIN equiv)	-	G
orphenadrine citrate ER tab (NORFLEX equiv)	-	G
tizanidine cap (ZANAFLEX equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
tizanidine tab (ZANAFLEX equiv)	-	G
BACLOFEN TAB 5MG	-	NC
carisoprodol tab 250mg (SOMA equiv)	-	NC
chlorzoxazone tab	-	NC
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC
CYCLOBENZAPRINE COMPOUND KIT	-	NC
cyclobenzaprine ER cap (AMRIX equiv)	-	NC
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	NC
metaxalone tab (SKELAXIN equiv)	-	NC
METAXALONE TAB 400MG	-	NC
METHOCARBAMOL TAB	-	NC
SOMA TAB 250MG	-	NC
DIRECT MUSCLE RELAXANTS		
dantrolene cap (DANTRIUM equiv)	-	G
FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) AGENTS		
SOHONOS CAP	-	NC
MUSCLE RELAXANT COMBINATIONS		
CARISOPRODOL/ASPIRIN TAB	-	NC
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	NC
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC
LORVATUS PHARMAPAK KIT	-	NC
NORGESIC TAB FORTE	-	NC
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	NC
TIZANIDINE COMFORT KIT	-	NC
VISCOSUPPLEMENTS		
DUROLANE INJ	LMSP-PA	B
GENVISC 850 INJ	-	NC
HYALGAN INJ	-	NC
HYMOVIS INJ	-	NC
ORTHOVISC/MONOVISC INJ	-	NC
SODIUM HYALU INJ	-	NC
TRIVISC INJ	-	NC
VISCO-3 INJ	-	NC
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
azelastine/fluticasone nasal spray (DYMISTA equiv)	-	NC
AZENASE PAK	-	NC
RYALTRIS SPRAY	-	NC
NASAL AGENTS - MISC.		
ALCOHOL SWABS	OTC	NC
ALZAIR NASAL SPRAY	-	NC
TICANASE PAK	-	NC
NASAL ANESTHETICS		
COCAINE HCL SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.

NASAL ANTIALLERGY

ASTEPRO NASAL SPRAY (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	B
azelastine nasal spray 0.1% (ASTELIN equiv)	-	G
azelastine nasal spray 0.15% (ASTEPRO equiv) (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	G
olopatadine nasal spray (PATANASE equiv)	-	NC

NASAL ANTICHOLINERGICS

ipratropium nasal spray (ATROVENT equiv)	-	G
--	---	---

NASAL ANTI-INFECTIVES

BACTROBAN NASAL OINT (QL= 10 tubes/fill)	QL	B
--	----	---

NASAL STEROIDS

BECONASE AQ NASAL SPRAY	-	EXC
budesonide nasal spray (RHINOCORT AQUA equiv)	OTC	EXC
FLONASE SENSIMIST NASAL SPRAY	OTC	EXC
flunisolide nasal soln	-	EXC
fluticasone nasal spray (FLONASE equiv)	-	EXC
mometasone nasal spray (NASONEX equiv)	-	EXC
OMNARIS NASAL SPRAY	-	EXC
QNASL NASAL SPRAY	-	EXC
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	EXC
XHANCE NASAL EXHALER	-	EXC
ZETONNA NASAL SPRAY	-	EXC

SYMPATHOMIMETIC DECONGESTANTS

ADRENALIN NASAL SOLN	-	NC
epinephrine hcl nasal soln (ADRENALIN equiv)	-	NC

NEUROMUSCULAR AGENTS

ALS AGENTS

RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
RELYVRIO PAK (QL= 2 packets/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
riluzole tab (RILUTEK equiv)	-	G
EXSERVAN FILM	-	NC
TIGLUTIK SUSP	-	NC

FRIEDRICH'S ATAXIA AGENTS

SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
---	----------	---

NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS

BOTOX INJ	MSP-PA	B
DYSPOIN INJ	MSP-PA	B
XEOMIN INJ	MSP-PA	B

RETT SYNDROME AGENTS

DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B
--	----------	---

SPINAL MUSCULAR ATROPHY AGENTS (SMA)

EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
--	----------	---

NUTRIENTS

LIPIDS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
NUTRIENTS Cont.		
DOJOLVI ORAL LIQUID	-	NC
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT OPHTH INSERT	-	NC
BETA-BLOCKERS - OPHTHALMIC		
BETIMOL OPHTH SOLN	-	B
BETOPTIC-S OPHTH SOLN	-	B
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	B
ISTALOL OPHTH SOLN	-	B
METIPRANOLOL OPHTH SOLN	-	B
BETAXOLOL OPHTH SOLN	-	G
betaxolol ophth soln (BETOPTIC-S equiv)	-	G
brimonidine/timolol ophth soln (COMBIGAN OPHTH SOLN equiv)	-	G
CARTEOLOL OPHTH SOLN	-	G
carteolol ophth soln (OCUPRESS equiv)	-	G
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	G
LEVOBUNOLOL OPHTH SOLN	-	G
levobunolol ophth soln (BETAGAN equiv)	-	G
timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv)	-	G
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	G
timolol maleate ophth soln (TIMOPTIC equiv)	-	G
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	G
timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv)	-	G
COMBIGAN OPHTH SOLN	-	NC
CHOLINERGIC AGONISTS		
TYRVAYA SOLN	-	NC
CYCLOPLEGIC MYDRIATICS		
CYCLOGYL OPHTH SOLN	-	B
CYCLOMYDRIL OPHTH SOLN	-	B
HOMATROPINE OPHTH SOLN	-	B
atropine ophth oint	-	G
atropine ophth soln (ISOPTO ATROPINE equiv)	-	G
ATROPINE SUL SOLN 1% OPHTH	-	G
ATROPINE SULFATE OPHTH OINT	-	G
cyclopentolate ophth soln (CYCLOGYL equiv)	-	G
phenylephrine ophth soln (MYDFRIN equiv)	-	G
tropicamide ophth soln (MYDRIACYL equiv)	-	G
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC
MIOTICS		
ISOPTO CARBACHOL OPHTH SOLN	-	B
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	G
PHOSPHOLINE OPHTH SOLN	-	NC
VUITY OPHTH SOLN	-	NC
OPHTHALMIC - ANGIOGENESIS INHIBITORS		
LUCENTIS INJ	MSP-PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
MACUGEN INJ	MSP-PA	B
OPHTHALMIC ADRENERGIC AGENTS		
APRACLONIDINE OPHTH SOLN	-	B
IOPIDINE OPHTH SOLN	-	B
SIMBRINZA OPHTH SUSP	-	B
apraclonidine ophth soln (IOPIDINE equiv)	-	G
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	G
brimonidine ophth soln 0.2%	-	G
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	G
ALPHAGAN P OPHTH SOLN 0.15%	-	NC
OPHTHALMIC ANTI-INFECTIVES		
AZASITE SOLN	-	B
BACITRACIN OPHTH OINT	-	B
CILOXAN OPHTH OINT	-	B
NATACYN OPHTH SUSP (QL= 15ml/fill)	QL	B
TOBREX OPHTH OINT	-	B
ZIRGAN OPHTH GEL	-	B
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	G
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	G
ciprofloxacin ophth soln (CILOXAN equiv)	-	G
erythromycin ophth oint	-	G
gatifloxacin ophth soln (ZYMAXID equiv)	-	G
GENTAK OPHTH OINT	-	G
gentamicin ophth soln (GARAMYCIN equiv)	-	G
levofloxacin ophth soln (QUIXIN equiv)	-	G
LEVOFLOXACIN OPHTH SOLN 0.5%	-	G
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	G
NEOMYCIN/POLYMXIN/GRAMICIDIN OPHTH SOLN	-	G
ofloxacin ophth soln (OCUFLOX equiv)	-	G
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	G
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	G
tobramycin ophth soln (TOBREX equiv)	-	G
TRIFLURIDINE OPHTH SOLN	-	G
BESIVANCE OPHTH SUSP	-	NC
ERYTHROMYCIN OPHTH OINT	-	NC
LEVOFLOXACIN OPHTH SOLN	-	NC
MOXEZA OPHTH SOLN 0.5%	-	NC
MOXEZA OPHTH SOLN, MOXIFLOXACIN OPHTH SOLN, VIGAMOX OPHTH SOLN	-	NC
MOXIFLOXACIN SOLN	-	NC
VANCOMYCIN SOLN	-	NC
VIGAMOX OPHTH SOLN	-	NC
XDEMVA DROPS	-	NC
OPHTHALMIC IMMUNOMODULATORS		
cyclosporine ophth emulsion (RESTASIS equiv)	PA	G
CEQUA (PF) OPHTH SOLN, VEVYE OPHTH SOLN	-	NC
CYCLOSPORINE OPHTH EMULSION 0.1%	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
RESTASIS MULTI-DOSE	-	NC
RESTASIS OPHTH EMULSION	-	NC
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA OPHTH SOLN	-	NC
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA OPHTH SOLN	-	NC
ROCKLATAN OPHTH SOLN	-	NC
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	G
IHEEZO GEL	-	NC
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523)	LD-PA-QL	B
OPHTHALMIC PHOTOENHANCERS		
PHOTREXA OP KIT	-	NC
PHOTREXA VISCOUS OPHTH SOLN	-	NC
OPHTHALMIC STEROIDS		
ALREX OPHTH SUSP	-	B
ALREX OPHTH SUSP 0.2%	-	B
BLEPHAMIDE OPHTH SOLN	-	B
BLEPHAMIDE S.O.P. OPHTH OINT	-	B
FLAREX OPHTH SUSP	-	B
FML FORTE OPHTH SUSP	-	B
FML S.O.P. OPHTH OINT	-	B
LOTEMAX OPHTH GEL	-	B
LOTEMAX OPHTH OINT	-	B
MAXIDEX OPHTH SOLN	-	B
PRED FORTE OPHTH SUSP	-	B
PRED MILD OPHTH SOLN	-	B
PRED-G OPHTH SOLN	-	B
TOBRADEX OPHTH OINT	-	B
TOBRADEX ST OPHTH SUSP	-	B
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	B
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	G
difluprednate ophth emulsion (DUREZOL equiv)	-	G
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	G
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	G
loteprednol ophth susp (LOTEMAX equiv)	-	G
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	G
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	G
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	G
PREDNISOLONE OPHTH SUSP	-	G
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	G
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	G
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	G
DEXTENZA OPHTH INSERT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
EYSUVIS OPHTH SUSP	-	NC
INVELTYS OPHTH SUSP	-	NC
KLARITY-B DROPS	-	NC
KLARITY-L DROPS	-	NC
LOTEMAX SM GEL 0.38%	-	NC
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP	-	NC
PREDNISOLONE/NEPAFENAC OPHTH SUSP	-	NC
OPHTHALMIC SURGICAL AIDS		
DUOVISC KIT	-	NC
OPHTHALMICS - MISC.		
ACUVAIL OPHTH SOLN	-	B
ALOCRIAL OPHTH SOLN	-	B
ALOMIDE OPHTH SOLN	-	B
AZOPT OPHTH SUSP	-	B
CYSTADROPS SOLN (QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	B
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B
ILEVRO OPHTH SUSP	-	B
NEVANAC OPHTH SUSP	-	B
PROLENSA OPHTH SOLN	-	B
ketotifen ophth soln (ZADITOR equiv)	OTC	EXC
UPNEEQ SOLN	-	EXC
azelastine ophth soln (OPTIVAR equiv)	-	G
brinzolamide ophth susp (AZOPT equiv)	-	G
bromfenac ophth soln (BROMDAY equiv)	-	G
cromolyn ophth soln (CROLOM equiv)	-	G
CROMOLYN SODIUM OPHTH SOLN	-	G
diclofenac sodium ophth soln (VOLTAREN equiv)	-	G
dorzolamide ophth soln (TRUSOPT equiv)	-	G
epinastine ophth soln (ELESTAT equiv)	-	G
ketorolac ophth soln (ACULAR (LS) equiv)	-	G
olopatadine ophth soln 0.1% (PATANOL equiv)	-	G
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%)	QL-ST	G
bepotastine ophth soln (BEPREVE equiv)	-	NC
bromfenac sodium ophth soln 0.07% (PROLENSA equiv)	-	NC
bromfenac sodium ophth soln 0.075% (BROMSITE equiv)	-	NC
BROMSITE DROP 0.075%	-	NC
EMADINE OPHTH SOLN	-	NC
FLURBIPROFEN OPHTH SOLN	-	NC
LASTACFT OPHTH SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
MIEBO OPHTH SOLN	-	NC
PAZEO OPHTH SOLN 0.7%	-	NC
ZADITOR OPHTH SOLN	OTC	NC
ZERVIATE OPHTH SOLN	-	NC
PROSTAGLANDINS - OPHTHALMIC		
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	G
travoprost ophth soln (TRAVATAN Z equiv) (QL= 5ml/30 days; Step Therapy requires trial of latanoprost)	QL-ST	G
bimatoprost ophth soln	-	NC
IYUZEH OPHTH DROPS	-	NC
LUMIGAN OPHTH SOLN	-	NC
tafluprost preservative free (pf) ophth soln (ZIOPTAN OPHTH SOLN equiv)	-	NC
VYZULTA SOLN	-	NC
XELPROS OPHTH EMULSION	-	NC
ZIOPTAN OPHTH SOLN	-	NC

OTIC AGENTS

OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	G
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	G
OTIC ANTI-INFECTIVES		
CIPROFLOXACIN OTIC SOLN	-	B
ofloxacin otic soln (FLOXIN equiv)	-	G
OTIC COMBINATIONS		
CIPRO HC OTIC SUSP (Step Therapy requires trial of CIPRODEX)	ST	B
COLY-MYCIN S OTIC SUSP	-	B
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	G
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	G
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	G
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC
CORTANE-B OTIC SOLN	-	NC
CORTIC-ND DROPS	-	NC
otomax-HC otic soln (CORTANE-B equiv)	-	NC
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	G
fluocinolone otic oil (DERMOTIC equiv)	-	G

OXYTOCICS

ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING		
MPM PAK	-	NC
OXYTOCICS		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	G

PASSIVE IMMUNIZING AGENTS

IMMUNE SERUMS		
CARIMUNE INJ	MSP-PA	B
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	MSP-PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

PASSIVE IMMUNIZING AGENTS Cont.

GAMASTAN S/D INJ	MSP-PA	B
GAMUNEX INJ	MSP-PA	B
HIZENTRA INJ	MSP-PA	B
CUVITRU INJ	-	NC

PASSIVE IMMUNIZING AGENTS - COMBINATIONS

HYQVIA INJ	MSP-PA	B
------------	--------	---

PASSIVE IMMUNIZING AND TREATMENT AGENTS

IMMUNE SERUMS

HIZENTRA INJ	MSP-PA	B
XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
CUTAQUIG INJ	-	NC

MONOCLONAL ANTIBODIES

BEYFORTUS INJ	VAC	\$0
---------------	-----	-----

PENICILLINS

AMINOPENICILLINS

amoxicillin cap (TRIMOX equiv)	-	G
AMOXICILLIN CHEW TAB	-	G
amoxicillin susp (TRIMOX equiv)	-	G
amoxicillin tab (AMOXIL equiv)	-	G
ampicillin cap (AMPICILLIN equiv)	-	G
MOXATAG TAB	-	NC
MOXATAG TAB 775MG	-	NC

NATURAL PENICILLINS

penicillin vk tab (VEETIDS equiv)	-	G
-----------------------------------	---	---

PENICILLIN COMBINATIONS

AMOXICILLIN/CLAVULANATE ER TAB	-	B
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	G
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	G

PENICILLINASE-RESISTANT PENICILLINS

dicloxacillin cap (DYNAPEN equiv)	-	G
-----------------------------------	---	---

PHARMACEUTICAL ADJUVANTS

LIQUID VEHICLES

TRICHOSOL SOLN	-	NC
----------------	---	----

SEMI SOLID VEHICLES

POLYETHYLENE GLYCOL 8000 GRANULES	-	B
VERSAPENN AL GEL ANHYDROU	-	NC

PROGESTINS

PROGESTINS

medroxyprogesterone tab (PROVERA equiv)	-	G
megestrol ES susp (MEGACE ES equiv)	-	G
norethindrone tab (AYGESTIN equiv)	-	G
progesterone cap (PROMETRIUM equiv)	-	G
progesterone oil inj	-	G

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	MSP	RDX	Over-the-Counter
RS	Prior Authorization	QL	SMKG	Restricted to Diagnosis
ST	Restricted to Specialist	SF	¢	Smoking Cessation
	Step Therapy	VAC		RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
AGENTS FOR CHEMICAL DEPENDENCY		
LUCEMYRA TAB (QL= 96 tabs/7 days)	PA-QL	B
acamprosate calcium DR tab (CAMPRAL equiv)	-	G
disulfiram tab (ANTABUSE equiv)	-	G
ANTI-CATAPLECTIC AGENTS		
SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	B
LUMRYZ PACK	-	NC
XYREM SOLN	-	NC
XYWAV SOLN	-	NC
ANTIDEMENTIA AGENTS		
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	G
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	G
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day)	QL	G
galantamine ER cap (RAZADYNE ER equiv)	-	G
GALANTAMINE SOLN	-	G
galantamine tab (RAZADYNE equiv)	-	G
memantine soln (NAMENDA equiv)	-	G
memantine tab (NAMENDA equiv)	-	G
rivastigmine cap (EXELON equiv)	-	G
rivastigmine patch (EXELON equiv)	-	G
ADLARITY PATCH	-	NC
memantine ER cap (NAMENDA XR equiv)	-	NC
NAMENDA XR CAP	-	NC
NAMENDA XR TITRATION PACK	-	NC
NAMZARIC CAP	-	NC
NAMZARIC STARTER PACK	-	NC
COMBINATION PSYCHOTHERAPEUTICS		
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	G
PERPHENAZINE/ AMITRIPTYLINE TAB	-	G
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	NC
DULOXICAINE PACK	-	NC
LYBALVI TAB	-	NC
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	B
SAVELLA TAB (QL= 2 tabs/day)	QL	B
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB	-	NC
VYLEESI INJ	-	NC
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB (QL= 4 tabs/day)	LMSP-PA-QL	B
AUSTEDO XR TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
AUSTEDO XR TAB 6MG (QL= 3 tabs/day)	LMSP-PA-QL	B
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days)	LMSP-PA-QL	B
INGREZZA CAP (QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
INGREZZA PACK 40-80MG (QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
tetrabenazine tab (XENAZINE equiv)	LMSP	G
AUSTEDO TITRATION PACK	-	NC
XENAZINE TAB	-	NC
MULTIPLE SCLEROSIS AGENTS		
AVONEX INJ	LMSP-PA	B
EXTAVIA INJ	LMSP-PA	B
KESIMPTA INJ	LMSP-PA	B
MAVENCLAD THERAPY PAK (Only available through Walgreens 888-347-3416)	LD	B
MAYZENT TAB	LMSP-PA	B
MAYZENT TAB STARTER PACK	LMSP-PA	B
PLEGRIDY INJ	LMSP-PA	B
PLEGRIDY PEN INJ	LMSP-PA	B
REBIF INJ	LMSP-PA	B
TYSABRI INJ	MSP-PA	B
ZEPOSIA CAP (QL= 1 cap/day)	LMSP-PA-QL	B
ZEPOSIA STARTER PACK (QL= 1 cap/day)	LMSP-PA-QL	B
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist)	LMSP-QL-RS	G
dimethyl fumarate DR cap (TECFIDERA equiv)	LMSP	G
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	LMSP	G
fingolimod hcl cap 0.5mg (GILENYA equiv)	LMSP	G
glatiramer inj (COPAXONE equiv)	LMSP-PA	G
teriflunomide tab (AUBAGIO equiv)	LMSP	G
AUBAGIO TAB	-	NC
BAFIERTAM CAP	-	NC
BETASERON INJ	-	NC
GILENYA CAP 0.25MG	-	NC
GILENYA CAP 0.5MG	-	NC
PONVORY TAB	-	NC
PONVORY TAB STARTER PACK	-	NC
TASCENSO ODT TAB	-	NC
TECFIDERA CAP	-	NC
TECFIDERA STARTER PACK	-	NC
VUMERITY CAP	-	NC
ZINBRYTA INJ	-	NC
POSTHERPETIC NEURALGIA (PHN) AGENTS		
GRALISE TAB	-	NC
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
gabapentin (once-daily) tab (GRALISE equiv)	-	NC
GRALISE STARTER PACK	-	NC
GRALISE TAB	-	NC
LIDOTIN PAK	-	NC
pregabalin ER tab (LYRICA CR equiv)	-	NC
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
FLUOXETINE CAP (PMDD)	-	NC
SARAFEM TAB	-	NC
PSEUDOBULBAR AFFECT (PBA) AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	B
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
PIMOZIDE TAB	-	B
ERGOLOID MESYLATES TAB	-	NC
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB	-	NC
SMOKING DETERRENENTS		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTINE KIT	OTC-QL-SMKG	\$0
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	\$0
varenicline tartrate tab (VARENICLINE equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
TEGSEDI INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
WAINUA INJ	-	NC
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP	-	NC
paroxetine cap (BRISDELLE equiv)	-	NC
RESPIRATORY AGENTS - MISC.		
ALPHA-PROTEINASE INHIBITOR (HUMAN)		
ARALAST/PROLASTIN/ZEMAIRA INJ	MSP-PA	B
GLASSIA INJ	MSP-PA	B
CYSTIC FIBROSIS AGENTS		
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
PULMOZYME INH SOLN	LMSP	B
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
BRONCHITOL CAP	-	NC
PULMONARY FIBROSIS AGENTS		
OFEV CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL-SF	B
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	LMSP-PA-QL-SF	G
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	LMSP-PA-QL-SF	G
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	LMSP-PA-QL-SF	G
ESBRIET CAP	-	NC
ESBRIET TAB 267MG	-	NC
ESBRIET TAB 801MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
RESPIRATORY AGENTS - MISC. Cont.		
PIRFENIDONE TAB	-	NC
SULFONAMIDES		
SULFONAMIDES		
sulfadiazine tab	-	G
SULFADIAZINE TAB	-	NC
TETRACYCLINES		
AMINOMETHYLCYCLINES		
NUZYRA TAB	-	NC
TETRACYCLINES		
VIBRAMYCIN SYRUP	-	B
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	G
doxycycline hyclate tab (VIBRATAB equiv)	-	G
doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv)	-	G
doxycycline monohydrate tab (ADOXA equiv)	-	G
doxycycline susp (VIBRAMYCIN equiv)	-	G
minocycline cap (MINOCIN equiv)	-	G
minocycline tab (DYNACIN equiv) (Step therapy requires trial of minocycline caps)	ST	G
tetracycline cap	-	G
ACTICLATE TAB 75MG, 150MG	-	NC
ADOXA CAP 150MG	-	NC
demeclocycline tab (DECLOMYCIN equiv)	-	NC
DORYX MPC TAB	-	NC
doxycycline hyclate DR tab (DORYX equiv)	-	NC
doxycycline hyclate tab (TARGADOX equiv)	-	NC
doxycycline hyclate tab 75mg, 150mg	-	NC
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	NC
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	NC
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC
doxycycline monohydrate tab 75mg (ADOXA equiv)	-	NC
MINOCYCLINE ER CAP	-	NC
minocycline ER tab (SOLODYN equiv)	-	NC
MINOLIRA TAB	-	NC
MONODOX CAP 75MG	-	NC
SEYSARA TAB	-	NC
TETRACYCLINE TAB	-	NC
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	G
propylthiouracil tab	-	G
SODIUM IODIDE I-131 SOLN	-	NC
THYROID HORMONES		
THYROLAR TAB	-	B
ARMOUR THYROID TAB, NATURE THROID TAB	-	G
levothyroxine tab (SYNTHROID equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
THYROID AGENTS Cont.		
liothyronine tab (CYTOMEL equiv)	-	G
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	G
ERMEZA SOLN 150 MCG/5ML	-	NC
LEVOTHYROXINE INJ	-	NC
LEVOTHYROXINE INJ 100MCG/ML	-	NC
SYNTHROID TAB	-	NC
THYQUIDITY SOLN	-	NC
TIROSINT CAP	-	NC
TIROSINT-SOL	-	NC

TOXOIDS

TOXOID COMBINATIONS

ADACEL/BOOSTRIX INJ	VAC	\$0
DAPTACEL INJ, INFANRIX INJ	VAC	\$0
DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	\$0
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	\$0
KINRIX PEF SYRINGE, QUADRACEL PEF SYRINGE	VAC	\$0
PEDIARIX INJ	VAC	\$0
PENTACEL INJ	VAC	\$0
TETANUS-DIPHTHERIA TOXOID INJ	VAC	\$0
VAXELIS INJ	VAC	\$0

ULCER DRUGS

ANTISPASMODICS

BELLADONNA ALKALOID/OPIUM SUPP	-	B
PROPANTHELINE TAB	-	B
SYMAX DUOTAB	-	B
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	G
dicyclomine cap (BENTYL equiv)	-	G
dicyclomine soln (BENTYL equiv)	-	G
dicyclomine tab (BENTYL equiv)	-	G
glycopyrrolate tab (ROBINUL equiv)	-	G
hyoscyamine sulfate CR tab (LEVBIID equiv)	-	G
hyoscyamine sulfate elixir (LEVSIN equiv)	-	G
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	G
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	G
hyoscyamine sulfate soln (LEVSIN equiv)	-	G
hyoscyamine tab (LEVSIN equiv)	-	G
methscopolamine tab (PAMINE equiv)	-	G
b-donna tab (DONNATAL equiv)	-	NC
DONNATAL TAB	-	NC
GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC
pb-belladonna elixir (DONNATAL equiv)	-	NC

H-2 ANTAGONISTS

NIZATIDINE SOLN (Members age 9 or older require Prior Authorization)	PA	B
cimetidine soln (CIMETIDINE equiv)	-	G
cimetidine tab (TAGAMET equiv) (Rx Only)	-	G
famotidine susp (PEPCID equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
L MSP	NC/3P = Not Covered, Third Party Reviewer	INF	OTC	Limited Distribution
PA	Plan Exclusion	MSP	RDX	Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	SMKG	Restricted to Diagnosis
ST	Prior Authorization	SF	¢	Smoking Cessation
	Restricted to Specialist	VAC		RxCENTS
	Step Therapy			

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.		
PRILOSEC OTC DR TAB	OTC	EXC
ACIPHEX SPRINKLE CAP 10MG, RABEPRAZOLE SPRINKLE CAP 10MG	-	NC
DEXILANT DR CAP	-	NC
dexlansoprazole DR cap (DEXILANT equiv)	-	NC
esomeprazole DR granule pack (NEXIUM equiv)	-	NC
FIRST PANTOPRAZOLE SUSP	-	NC
lansoprazole odt (PREVACID SOLUTAB equiv)	-	NC
pantoprazole sodium packet (PROTONIX equiv)	-	NC
PREVACID CAP	-	NC
VOQUEZNA TAB	-	NC
ULCER THERAPY COMBINATIONS		
bismuth/metro/tetra cap (PYLERA equiv)	-	NC
HELIDAC PACK	-	NC
KONVOMEK SUSP	-	NC
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	NC
LANSOPRAZOLE/AMOXICILLIN/CLARITHROMYCIN KIT	-	NC
PYLERA CAP	-	NC
TALICIA CAP	-	NC
VOQUEZNA DUAL PAK	-	NC
VOQUEZNA TRIP PAK	-	NC

URINARY ANTI-INFECTIVES

DrugName	Special Code	Tier
URINARY ANTI-INFECTIVE COMBINATIONS		
PROSED DS TAB	-	NC

URINARY ANTISPASMODICS

DrugName	Special Code	Tier
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)		
tropium chloride SR cap (SANCTURA XR equiv)	-	G

DrugName	Special Code	Tier
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
OXYTROL PATCH (OTC)	OTC	EXC
oxybutynin ER tab (DITROPAN XL equiv)	-	G
oxybutynin syrup	-	G
oxybutynin tab (DITROPAN equiv)	-	G
solifenacin tab (VESICARE equiv)	-	G
tolterodine SR cap (DETROL LA equiv)	-	G
tolterodine tab (DETROL equiv)	-	G
tropium tab (SANCTURA equiv)	-	G
darifenacin SR tab (ENABLEX equiv)	-	NC
DETROL LA CAP	-	NC
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	NC
GELNIQUE	-	NC
OXYBUTYNIN TAB	-	NC
TOVIAZ TAB	-	NC
VESICARE LS SUSP	-	NC
VESICARE TAB	-	NC

DrugName	Special Code	Tier
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
----------	--------------	------

URINARY ANTISPASMODICS Cont.

MYRBETRIQ SUSP	-	NC
MYRBETRIQ TAB	-	NC

URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS

bethanechol tab (URECHOLINE equiv)	-	G
------------------------------------	---	---

URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS (NEW)

flavoxate tab (URISPAS equiv)	-	G
-------------------------------	---	---

VACCINES

BACTERIAL VACCINES

ACTHIB INJ, HIBERIX INJ	VAC	\$0
BEXSERO INJ	VAC	\$0
MENACTRA INJ	VAC	\$0
MENQUADFI INJ	VAC	\$0
MENVEO INJ	VAC	\$0
PEDVAXHIB INJ	VAC	\$0
PENBRAYA INJ	VAC	\$0
PNEUMOVAX INJ	VAC	\$0
PREVNAR 13 INJ	VAC	\$0
PREVNAR 20 INJ (Covered for members age 19 years or older)	VAC	\$0
TRUMENBA INJ	VAC	\$0
VAXNEUVANCE INJ	VAC	\$0
BCG INJ	VAC	EXC

VIRAL VACCINES

ABRYSCO INJ	VAC	\$0
AFLURIA INJ (QL= 1 inj/28 days)	QL-VAC	\$0
AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days)	QL-VAC	\$0
AREXVY INJ	VAC	\$0
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	\$0
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ 5-11Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-4Y (PFIZER) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-5Y (MODERNA) (QL= 1 inj/fill)	QL-VAC	\$0
COVID-19 VACCINE INJ (JANSSEN) (QL= 1 dose/45 days)	QL-VAC	\$0
COVID-19 VACCINE INJ (NOVAVAX) (QL= 1 dose/17 days)	QL-VAC	\$0
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	\$0
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	\$0
DENGXVAXIA SUSP	VAC	\$0
ENGERIX-B/RECOMBIVAX-HB INJ	VAC	\$0
FLUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0
FLUAD QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0
FLUBLOK QUAD PF INJ (QL= 1 inj/28 days)	QL-VAC	\$0
FLUCELVAX QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0
FLULAVAL QUAD INJ, FLUZONE QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0
FLUMIST QUADRIVALENT NASAL SUSP (QL= 1 inj/28 days)	QL-VAC	\$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered	generic = small letters	BRANDS = CAPITAL LETTERS
NC/3P = Not Covered, Third Party Reviewer		
EXC Plan Exclusion	INF Infertility	LD Limited Distribution
LMSP Lumicera Mandatory Specialty Pharmacy Program	MSP Mandatory Specialty Pharmacy Program	OTC Over-the-Counter
PA Prior Authorization	QL Quantity Limit	RDX Restricted to Diagnosis
RS Restricted to Specialist	SF Limited to two 15 day fills per month for first 3 months	SMKG Smoking Cessation
ST Step Therapy	VAC Vaccine Program	¢ RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
VACCINES Cont.		
FLUZONE HD PF INJ (QL= 1 inj/28 days)	QL-VAC	\$0
FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days)	QL-VAC	\$0
FLUZONE/FLUARIX QUAD INJ (QL= 1 inj/28 days)	QL-VAC	\$0
GARDASIL 9 INJ	VAC	\$0
HAVRIX INJ, VAQTA INJ	VAC	\$0
HEPLISAV-B INJ	VAC	\$0
IPOL INJ	VAC	\$0
M-M-R II INJ	VAC	\$0
PREHEVBRIO SUSP	VAC	\$0
PRIORIX INJ	VAC	\$0
PROQUAD INJ	VAC	\$0
ROTARIX SUSP	VAC	\$0
ROTATEQ INJ	VAC	\$0
SHINGRIX INJ (Covered for members age 19 years or older)	VAC	\$0
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	\$0
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	\$0
TWINRIX INJ	VAC	\$0
VARIVAX INJ	VAC	\$0
IMOVAX INJ	VAC	EXC
RABAVERT INJ	VAC	EXC
IXCHIQ INJ	-	NC

VAGINAL AND RELATED PRODUCTS

VAGINAL ANTI-INFECTIVES

CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	B
XACIATO GEL (QL= 1 applicator/fill)	QL	B

VAGINAL CONTRACEPTIVE - PH MODULATORS

PHEXXI GEL (QL= 1 box/fill)	QL	\$0
-----------------------------	----	-----

VAGINAL PRODUCTS

MISCELLANEOUS VAGINAL PRODUCTS

FEM PH GEL	-	B
INTRAROSA SUPP	-	NC

SPERMICIDES

CONTRACEPTIVE FOAM	OTC	\$0
CONTRACEPTIVE GEL	OTC	\$0
CONTRACEPTIVE SUPP	OTC	\$0
TODAY SPONGE	OTC	\$0

VAGINAL ANTI-INFECTIVES

clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	G
metronidazole vaginal gel (METROGEL equiv)	-	G
terconazole cream (TERAZOL equiv)	-	G
TERCONAZOLE CREAM 0.8%	-	G
terconazole supp (TERAZOL equiv)	-	G
CLEOCIN VAGINAL SUPP	-	NC

VAGINAL ESTROGENS

ESTRING (3 copays per Rx)	-	B
---------------------------	---	---

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered	generic = small letters	LD	BRANDS = CAPITAL LETTERS
LMSP	NC/3P = Not Covered, Third Party Reviewer	INF	OTC	Limited Distribution
PA	Plan Exclusion	MSP	RDX	Over-the-Counter
RS	Lumicera Mandatory Specialty Pharmacy Program	QL	SMKG	Restricted to Diagnosis
ST	Prior Authorization	SF	¢	Smoking Cessation
	Restricted to Specialist	VAC		RxCENTS
	Step Therapy			

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Category/Class**

Last Updated* 3/1/2024

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
FEMRING (3 copays per Rx)	-	B
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill)	QL	G
ESTRACE VAGINAL CREAM	-	NC
estradiol cream (ESTRACE equiv)	-	NC
IMVEXXY SUPP	-	NC
PREMARIN VAGINAL CREAM	-	NC
VAGINAL PROGESTINS		
CRINONE GEL	PA	B
ENDOMETRIN INSERT	PA	B
PROGESTERONE SUPP	PA	B
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	G
ADRENALIN INJ, EPINEPHRINE INJ	-	NC
AUVI-Q INJ	-	NC
EPIPEN (JR) INJ	-	NC
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
droxidopa cap (NORTHERA equiv)	-	NC
NORTHERA CAP	-	NC
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	G
VITAMINS		
OIL SOLUBLE VITAMINS		
phytonadione tab (MEPHYTON equiv)	-	G
vitamin D cap (RX strength only)	-	G
ERGOCAL CAP	-	NC
vitamin D cap 1000unit	OTC	NC
vitamin D cap 400unit	OTC	NC
VITAMIN D TAB 2000IU	OTC	NC
VITAMIN D TAB 400UNIT	OTC	NC
WATER SOLUBLE VITAMINS		
POTABA POWDER PACKET	-	B
niacin cap	OTC	EXC
niacin CR tab (SLO-NIACIN equiv)	OTC	EXC
niacin tab	OTC	EXC
NIACIN TR TAB	OTC	EXC
niacinamide tab	OTC	EXC
pyridoxine inj	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

EXC	NC = Not Covered NC/3P = Not Covered, Third Party Reviewer	INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RDX	Restricted to Diagnosis
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation
ST	Step Therapy	VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Prior Authorization Drug List
Last Updated* 3/1/2024

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ABSTRAL SL TAB	B
ACCU-CHEK AVIVA PLUS METER	B
ACCU-CHEK AVIVA PLUS TEST STRIP	B
ACCU-CHEK GUIDE CARE METER	B
ACCU-CHEK GUIDE ME KIT	B
ACCU-CHEK GUIDE TEST STRIP	B
ACCU-CHEK NANO METER	B
ACCU-CHEK SMARTVIEW TEST STRIP	B
ACCU-CHEK TEST STRIP	B
ACTEMRA ACTPEN INJ	B
ACTEMRA IV INJ	B
ACTEMRA SC INJ	B
ACTHAR GEL INJ	B
ACTIMMUNE INJ	B
ADAGEN INJ	B
ADALIMUMAB-ADAZ INJ	B
ADALIMUMAB-ADAZ PFS INJ	B
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	B
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	B
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	B
ADBRY INJ	B
ADEMPAS TAB	B
ADVATE INJ	B
AIMOVIG INJ	B
AJOVY INJ	B
ALDURAZYME INJ	B
ALECENSA CAP	B
ALINIA SUSP	B
ALKINDI SPRINKLE CAP 0.5MG	B
ALKINDI SPRINKLE CAP 1MG	B
ALPHANATE/HEMOFIL/KOATE INJ	B
ALPHANINE SD/MONONINE INJ	B
ALUNBRIG TAB 30MG	B
ALUNBRIG TAB 90MG, 180MG	B
ambrisentan tab	G
ANDRODERM PATCH	B
ARALAST/PROLASTIN/ZEMAIRA INJ	B
ARIKAYCE SUSP	B
armodafanil tab	G
ARZERRA INJ	B
ATORVALIQ SUSP	B
AUSTEDO TAB	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
 Prior Authorization Drug List
 Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
AUSTEDO XR TAB	B
AUSTEDO XR TAB 6MG	B
AUSTEDO XR TAB TITRATION KIT	B
AVASTIN INJ	B
AVONEX INJ	B
AVSOLA INJ	B
AYVAKIT TAB	B
BACLOFEN ORAL SOLN 10 MG/5ML	B
BACLOFEN ORAL SOLN 5 MG/5ML	B
BACLOFEN SUSP	B
BALVERSA TAB 3MG	B
BALVERSA TAB 4MG	B
BALVERSA TAB 5MG	B
BANZEL SUSP	B
BARACLUDE SOLN	B
BEBULIN/PROFILNINE INJ	B
BENEFIX INJ	B
BENEFIX/RIXUBIS INJ	B
BENLYSTA AUTO-INJECTOR	B
BENLYSTA INJ	B
BERINERT INJ	B
bexarotene cap	G
bexarotene gel	G
bortezomib inj	B
bosentan tab	G
BOSULIF TAB	B
BOTOX INJ	B
BRAFTOVI CAP 75MG	B
BRUKINSA CAP	B
budesonide ER tab	G
butalbital/acetaminophen tab 50-325mg	G
butalbital/acetaminophen/caffeine tab	G
butalbital/aspirin/caffeine cap	G
BYLVAY CAP 1200MCG	B
BYLVAY CAP 400MCG	B
BYLVAY SPRINKLE CAP 200MCG	B
BYLVAY SPRINKLE CAP 600MCG	B
CABLIVI INJ KIT	B
CABOMETYX TAB	B
CALQUENCE CAP	B
CALQUENCE TAB	B
CAMZYOS CAP	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
CAPRELSA TAB	B
carglumic acid tab	G
CARIMUNE INJ	B
CAROSPIR SUSP	B
CAYSTON INH SOLN	B
CEREZYME INJ	B
CHOLBAM CAP	B
CIBINQO TAB	B
CIMZIA INJ	B
CIMZIA STARTER INJ KIT	B
CINRYZE INJ	B
clobazam susp	G
clobazam tab	G
clobetasol foam	G
clobetasol lotion	G
COMETRIQ KIT	B
COPIKTRA CAP	B
CORLANOR SOLN	B
CORLANOR TAB	B
COTELLIC TAB	B
CRINONE GEL	B
cyclosporine ophth emulsion	G
CYSTADANE POWDER	B
DAYBUE SOLN	B
deferiprone tab	G
DESCOVY TAB	\$0
DIABETIC METER	B
DIACOMIT CAP	B
DIACOMIT POWDER PACK	B
diclofenac gel	G
dihydroergotamine mesylate nasal spray	G
DOPTELET TAB	B
dronabinol cap	G
DUPIXENT INJ	B
DUPIXENT PEN INJ	B
DUROLANE INJ	B
DYSPORT INJ	B
ELAPRASE INJ	B
EMGALITY INJ	B
EMGALITY INJ 100MG/ML	B
EMPAVELI INJ	B
enalapril maleate oral soln	G

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ENBREL INJ 25MG	B
ENBREL INJ 50MG	B
ENBREL MINI INJ	B
ENBREL SURECLICK INJ 50MG	B
ENDARI POWDER PACK	B
ENDOMETRIN INSERT	B
ENSPRYNG INJ	B
EPIDIOLEX SOLN	B
EPRONTIA SOLN	B
ERIVEDGE CAP	B
ERLEADA TAB	B
ERLEADA TAB 240MG	B
erlotinib tab	G
erlotinib tab 25mg	G
esomeprazole cap	G
everolimus tab	G
everolimus tab for oral susp	G
EVRYSDI SOLN	B
EXTAVIA INJ	B
EZALLOR SPRINKLE CAP	B
FABRAZYME INJ	B
FASENRA PEN INJ	B
FEIBA INJ	B
fentanyl citrate lollipop	G
FENTORA TAB, FENTANYL BUCCAL TAB	B
FERRIPROX SOLN	B
FILSPARI TAB	B
FINTEPLA SOLN	B
FIRDAPSE TAB	B
FIRST OMEPRAZOLE SUSP	B
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	B
FLEQSUVY SUSP	B
FLOLIPID SUSP	B
FOTIVDA CAP	B
GALAFOLD CAP	B
GAMASTAN S/D INJ	B
GAMUNEX INJ	B
GAVRETO CAP	B
gefitinib tab	G
GENOTROPIN INJ	B
GILOTRIF TAB	B
GLASSIA INJ	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
glatiramer inj	G
GLOPERBA SOLN	B
HADLIMA INJ	B
HADLIMA INJ 40MG/0.8ML	B
HADLIMA PUSH INJ	B
HADLIMA PUSH INJ 40MG/0.8ML	B
HAEGARDA INJ	B
HELIXATE/KOGENATE INJ	B
HEMLIBRA INJ	B
HERCEPTIN INJ	B
HIZENTRA INJ	B
HUMATE-P/WILATE INJ	B
HUMIRA INJ 10MG	B
HUMIRA INJ 20MG	B
HUMIRA INJ 40MG	B
HUMIRA INJ 80MG	B
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	B
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	B
HUMIRA INJ PEDIATRIC UC STARTER PACK	B
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	B
HUMIRA PEN INJ 40MG	B
HYCAMTIN CAP	B
HYFTOR GEL	B
HYQVIA INJ	B
icatibant inj	G
ICLUSIG TAB	B
IDHIFA TAB	B
IMBRUVICA CAP 140MG	B
IMBRUVICA CAP 70MG	B
IMBRUVICA SUSP	B
IMBRUVICA TAB 420MG, 560MG	B
IMCIVREE INJ	B
INBRIJA INH POWDER	B
INGREZZA CAP	B
INGREZZA PACK 40-80MG	B
INLYTA TAB	B
INQOVI TAB	B
ISTURISA TAB 10MG	B
ISTURISA TAB 1MG	B
ISTURISA TAB 5MG	B
itraconazole soln	G
ivermectin tab	G

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
JAKAFI TAB	B
JAYPIRCA TAB	B
JOENJA TAB	B
JYLAMVO SOLN, XATMEP SOLN	B
JYNARQUE PAK	B
JYNARQUE TAB	B
KALYDECO PAK	B
KALYDECO TAB	B
KATERZIA SUSP	B
KERENDIA TAB	B
KESIMPTA INJ	B
KEVZARA INJ	B
KINERET INJ	B
KISQALI PAK	B
KISQALI TAB	B
KOSELUGO CAP	B
KOSELUGO CAP 10MG	B
KRAZATI TAB	B
LANSOPRAZOLE SUSP	B
lapatinib ditosylate tab	G
LAZANDA NASAL SPRAY	B
LEDIPASVIR/SOFOSBUVIR TAB	B
LENVIMA CAP	B
LIKMEZ SUSP	B
LINZESS CAP	B
lisdexamfetamine dimesylate chew tab	G
LIVMARLI SOLN	B
LIVTENCITY TAB	B
LOKELMA PAK	B
LONSURF TAB	B
LORBRENA TAB 25MG	B
lubiprostone cap	G
LUCEMYRA TAB	B
LUCENTIS INJ	B
LUMAKRAS TAB	B
LUMAKRAS TAB 320MG	B
LUMIZYME/MYOZYME INJ	B
LUPKYNIS CAP	B
LYNPARZA TAB	B
LYTGOBI THERAPY PACK	B
LYVISPAH GRANULE PACKET	B
MACUGEN INJ	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
MAVYRET PAK	B
MAVYRET TAB	B
MAYZENT TAB	B
MAYZENT TAB STARTER PACK	B
MEKINIST SOLN	B
MEKINIST TAB 0.5MG	B
MEKINIST TAB 2MG	B
MEKTOVI TAB	B
mifepristone tab	B
miglustat cap	G
modafinil tab	G
MONOCLATE-P INJ	B
MOTEGRITY TAB	B
MOVANTIK TAB	B
MOZOBIL INJ	B
MYFEMBREE TAB	B
NAGLAZYME INJ	B
NATPARA INJ	B
NERLYNX TAB	B
NEUPRO PATCH	B
NEXLETOL TAB	B
NINLARO CAP	B
nitazoxanide tab	G
NIZATIDINE SOLN	B
NORLIQVA ORAL SOLN	B
NOVOSEVEN INJ	B
NPLATE INJ	B
NUBEQA TAB	B
NUCALA INJ	B
NUEDEXTA CAP	B
OCALIVA TAB	B
ODOMZO CAP	B
OFEV CAP	B
OLUMIANT TAB	B
OMNITROPE INJ	B
ONGENTYS CAP	B
OPSUMIT TAB	B
OPZELURA CREAM	B
ORENCIA CLICK INJ	B
ORENCIA SC INJ 125MG/ML	B
ORENCIA SC INJ 50MG/0.4ML	B
ORENCIA SC INJ 87.5MG/0.7ML	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ORGOVYX TAB	B
ORIAHNN CAP	B
ORILISSA TAB 150MG	B
ORILISSA TAB 200MG	B
ORKAMBI GRANULES PACKET	B
ORKAMBI TAB	B
ORSERDU TAB	B
ORSERDU TAB 345MG	B
OTEZLA STARTER PACK	B
OTEZLA TAB	B
OXBRYTA TAB	B
OXBRYTA TAB FOR ORAL SUSP	B
OXERVATE OPHTH SOLN	B
PALFORZIA POWDER PACK	B
PALFORZIA SPRINKLE CAP	B
PALYNZIQ INJ	B
pazopanib tab	G
PEG-PREP KIT	B
PEMAZYRE TAB	B
PIQRAY TAB	B
pirfenidone cap	G
pirfenidone tab 267mg	G
pirfenidone tab 801mg	G
PLEGRIDY INJ	B
PLEGRIDY PEN INJ	B
plerixafor subcutaneous inj	B
POMALYST CAP	B
posaconazole DR tab	G
posaconazole susp	G
PREVYMIS TAB	B
PROGESTERONE SUPP	B
PROMACTA POWDER	B
PROMACTA TAB	B
PURIXAN SUSP	B
pyrimethamine tab	G
PYRUKYND TAB	B
PYRUKYND TAPER PACK	B
QBRELIS SOLN	B
QINLOCK TAB	B
rabeprazole EC tab	G
RADICAVA ORS STARTER KIT	B
RADICAVA ORS SUSP	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ramelteon tab	G
REBIF INJ	B
RECOMBINATE INJ	B
RELYVRIO PAK	B
RENFLEXIS INJ	B
REPATHA INJ	B
REPATHA PUSHTRONEX INJ	B
RETEVMO CAP	B
REYVOW TAB	B
REZLIDHIA CAP	B
REZUROCK TAB	B
RIASTAP INJ	B
RINVOQ ER TAB	B
RIOMET ER SUSP	B
RITUXAN INJ	B
roflumilast tab	G
ROZLYTREK CAP	B
ROZLYTREK PAK	B
RUBRACA TAB	B
RUCONEST INJ	B
rufinamide susp	G
rufinamide tab	G
RYDAPT CAP	B
sapropterin dihydrochloride powder packet	G
sapropterin dihydrochloride soluble tab	G
SIGNIFOR INJ	B
sildenafil susp	G
sildenafil tab 20mg	G
SIMPONI AUTO-INJECTOR 100MG	B
SIMPONI INJ 100MG	B
SKYCLARYS CAP	B
SKYRIZI INJ 150MG/ML	B
SKYRIZI INJ 180 MG/1.2ML	B
SKYRIZI INJ 360MG/2.4ML	B
SKYRIZI INJ 75MG/0.83ML	B
SKYTROFA INJ	B
SODIUM OXYBATE SOLN	B
SOFOSBUVIR/VELPATASVIR TAB	B
SOMAVERT INJ	B
sorafenib tosylate tab	G
SOTYLIZE SOLN 5MG/ML	B
spironolactone susp	G

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
SPORANOX SOLN	B
SPRIX NASAL SPRAY	B
SPRYCEL TAB	B
STELARA INJ	B
STIVARGA TAB	B
STRENSIQ INJ	B
sucralfate susp	G
sunitinib malate cap	G
SUNOSI TAB	B
SUPPRELIN LA INJ	B
SYMDEKO TAB	B
SYMLINPEN INJ	B
SYMPROIC TAB	B
TABRECTA TAB	B
tadalafil tab (PAH)	G
TADLIQ SUSP	B
TAFINLAR CAP	B
TAFINLAR TAB	B
TAGRISSO TAB	B
TAKHZYRO INJ	B
TAKHZYRO INJ 150MG/ML	B
TALTZ INJ	B
TALZENNA CAP 0.25MG	B
TALZENNA CAP 0.5MG, 0.75MG, 1MG	B
TASIGNA CAP	B
TAVALISSE TAB	B
TAVNEOS CAP	B
tazarotene cream 0.1%	G
TAZORAC CREAM 0.05%	B
TAZVERIK TAB	B
TEGSEDI INJ	B
temsirrolimus inj	B
TEPMETKO TAB	B
TEST STRIP (all other test strips)	B
testosterone gel pump 1.62%	G
testosterone soln	G
TEZSPIRE INJ	B
TIBSOVO TAB	B
tiopronin tab	G
TOBI PODHALER	B
TORISEL INJ	B
TRACLEER TAB 32MG	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
TREMFYA INJ	B
treprostinil inj 10mg/ml	B
treprostinil inj 1mg/ml	B
treprostinil inj 2.5mg/ml	B
treprostinil inj 5mg/ml	B
tretinoin cream	G
tretinoin gel	G
trientine cap	G
TRIKAFTA TAB	B
TRIKAFTA THERAPY PACK	B
TRINTELLIX TAB	B
TRULANCE TAB	B
TUKYSA TAB	B
TURALIO CAP	B
TYSABRI INJ	B
TYVASO DPI POWDER	B
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	B
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	B
TYVASO DPI POWDER TITRATION KIT 16-32MCG	B
TYVASO INH SOLN 0.6 MG/ML	B
UBRELVY TAB	B
UPTRAVI TAB	B
VALCHLOR GEL	B
VASCEPA CAP	G
VELTASSA POWDER	B
VEMLIDY TAB	B
VENCLEXTA STARTER PACK	B
VENCLEXTA TAB	B
VENTAVIS INH SOLN	B
VEOZAH TAB	B
VERZENIO TAB	B
vigabatrin powder pack	G
vigabatrin tab	G
vigadrone powder pack	G
VIJOICE TAB	B
VIJOICE TAB 250MG	B
VITRAKVI CAP 100MG	B
VITRAKVI CAP 25MG	B
VITRAKVI SOLN	B
VIZIMPRO TAB	B
VONJO CAP	B
VOSEVI TAB	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List cont.
 Prior Authorization Drug List
 Last Updated* 3/1/2024**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
VOWST CAP	B
VOXZOGO INJ	B
VPRIV INJ	B
VYNDAMAX CAP	B
VYNDAQEL CAP	B
WAKIX TAB	B
WELIREG TAB	B
XADAGO TAB	B
XALKORI CAP	B
XALKORI SPRINKLE CAP	B
XELJANZ SOLN	B
XELJANZ TAB	B
XELJANZ XR TAB	B
XEMBIFY INJ	B
XEOMIN INJ	B
XIAFLEX INJ	B
XIFAXAN TAB 200MG	B
XIFAXAN TAB 550MG	B
XOLAIR INJ	B
XOLAIR SYRINGE	B
XOLAIR SYRINGE 150MG/ML	B
XOSPATA TAB	B
XPHOZAH TAB	B
XPOVIO PAK	B
XYNTHA INJ	B
ZAVZPRET NASAL SPRAY	B
ZEJULA CAP	B
ZEJULA TAB	B
ZELBORAF TAB	B
ZEPOSIA CAP	B
ZEPOSIA STARTER PACK	B
ZOKINVY CAP	B
ZOLINZA CAP	B
zolmitriptan ODT	G
zolmitriptan tab	G
ZONISADE SUSP	B
ZORYVE CREAM	B
ZTALMY SUSP	B
ZYDELIG TAB	B
ZYKADIA CAP	B
ZYKADIA TAB	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Last Updated* 3/1/2024
RxCents (Cost Savings Enabled by Tablet Splitting)

Tablet splitting helps control prescription drug benefit costs and can provide significant savings for members. Participation in the program is voluntary. Through this program, members pay up to one-half of their usual copayment on a select group of prescription drugs. Drugs included in this program are based on the following criteria:

- The drug product is on the formulary.
- The drug product is recognized as an appropriate product to split by the Pharmacy & Therapeutics Committee.
- The drug is flat priced (i.e. various strengths of the medication must be comparably priced).
- The medication must have once-daily dosing.

An example of the savings that can be realized through this program is illustrated below:

	Product & Strength	Quantity	Member Copay	Member Annual Savings
Without Tablet Splitting	Drug A 40 mg tab	30	\$15.00	
With Tablet Splitting	Drug A 80 mg tab	15	\$7.50	\$90

As the example illustrates, tablet splitting allows members to receive the same dose in a fewer number of tablets; thus, the overall

RxCents Program Medications

febuxostat tab
 rasagiline tab

JANUVIA TAB
 TRINTELLIX TAB

nebivolol hcl tab

OCALIVA TAB

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Last Updated* 3/1/2024
Over-the-Counter (OTC)**

- The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

ACCU-CHEK AVIVA PLUS METER	ACCU-CHEK AVIVA PLUS TEST STRIP	ACCU-CHEK GUIDE CARE METER	ACCU-CHEK GUIDE ME KIT
ACCU-CHEK GUIDE TEST STRIP	ACCU-CHEK NANO METER	ACCU-CHEK SMARTVIEW TEST STRIP	ACCU-CHEK TEST STRIP
AEROCHAMBER	aspirin chew tab 81mg	aspirin ec tab 81mg	B-D INSULIN SYRINGE
B-D PEN NEEDLE	CALIBRATION LIQUID	CARETOUCH MIS	CLINISTIX TEST STRIP
CONTRACEPTIVE FOAM	CONTRACEPTIVE GEL	CONTRACEPTIVE SUPP	DIABETIC METER
FEMALE CONDOMS	folic acid tab 400mcg	folic acid tab 800mcg	GUAIFENESIN/CODEINE SYRUP
HUMULIN MIX INJ	HUMULIN MIX PEN INJ	HUMULIN N INJ	HUMULIN N PEN INJ
HUMULIN R INJ	KETO-DIASTIX TEST STRIF	KETOSTIX	LANCET KIT
LANCETS	levonorgestrel tab	MALE CONDOMS	naloxone hcl nasal spray
NARCAN NASAL SPRAY	nicotine gum	NICOTINE KIT	nicotine lozenge
nicotine patch	NOVOFINE PEN NEEDLE	NOVOTWIST PEN NEEDLE	NOVOTWIST/NOVOFINE PEN NEEDLE
ONETOUCH DELICA LANCETS	ONETOUCH DELICA PLUS LANCETS	ONETOUCH DELICA ULTRASOFT LANCETS	ONETOUCH KIT
ONETOUCH METER	ONETOUCH TEST STRIP	ONETOUCH VERIO FLEX METER	ONETOUCH VERIO METER
ONETOUCH VERIO REFLECT METER	ONETOUCH VERIO TEST STRIP	PEAK FLOW METER	PLAN B TAB
TEST STRIP (all other test strips)	TODAY SPONGE		

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Last Updated* 3/1/2024
Mandatory Specialty Pharmacy (MSP)**

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

abiraterone tab 250mg	ACTEMRA ACTPEN INJ	ACTEMRA IV INJ	ACTEMRA SC INJ
ACTHAR GEL INJ	ACTIMMUNE INJ	ADAGEN INJ	ADALIMUMAB-ADAZ INJ
ADALIMUMAB-ADAZ PFS	ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PFS	ADALIMUMAB-FKJP PFS
INJ	AUTO-INJECTOR KIT	KIT 20 MG/0.4ML	KIT 40 MG/0.8ML
ADBRY INJ	ADEMPAS TAB	ADVATE INJ	ALDURAZYME INJ
ALECENSA CAP	ALFERON-N INJ	ALPHANATE/HEMOFIL/KOATE INJ	ALPHANINE SD/MONONINE INJ
ALUNBRIG TAB 30MG	ALUNBRIG TAB 90MG, 180MG	ambrisentan tab	ARALAST/PROLASTIN/ZEM
ARIKAYCE SUSP	ARZERRA INJ	AUSTEDO TAB	AIRA INJ
AUSTEDO XR TAB 6MG	AUSTEDO XR TAB TITRATION KIT	AVASTIN INJ	AUSTEDO XR TAB
AVSOLA INJ	AYVAKIT TAB	azacitidine inj	AVONEX INJ
BALVERSA TAB 4MG	BALVERSA TAB 5MG	BEBULIN/PROFILNINE INJ	BALVERSA TAB 3MG
BENEFIX/RIXUBIS INJ	BENLYSTA AUTO-INJECTOR	BENLYSTA INJ	BENEFIX INJ
betaine powder for oral solution	bexarotene cap	bexarotene gel	BERINERT INJ
bosentan tab	BOSULIF TAB	BOTOX INJ	bortezomib inj
BRIXADI SOLN 128MG/0.36ML	BRIXADI SOLN 16MG/0.32ML	BRIXADI SOLN 24MG/0.48ML	BRAFTOVI CAP 75MG
BRIXADI SOLN 64MG/0.18ML	BRIXADI SOLN 8MG/0.16ML	BRIXADI SOLN 96MG/0.27ML	BRIXADI SOLN 32MG/0.64ML
BYLVAY CAP 1200MCG	BYLVAY CAP 400MCG	BYLVAY SPRINKLE CAP 200MCG	BRUKINSA CAP
CABLIVI INJ KIT	CABOMETYX TAB	CALCITRIOL INJ	BYLVAY SPRINKLE CAP 600MCG
CALQUENCE TAB	CAMZYOS CAP	capecitabine tab	CALQUENCE CAP
carglumic acid tab	CARIMUNE INJ	CAYSTON INH SOLN	CAPRELSA TAB
cetorelix acetate for inj kit	CETROTIDE KIT	CHOLBAM CAP	CEREZYME INJ
CIMZIA INJ	CIMZIA STARTER INJ KIT	CINRYZE INJ	CIBINQO TAB
COMETRIQ KIT	COPIKTRA CAP	COTELLIC TAB	colistimethate inj
CYSTADROPS SOLN	CYSTAGON CAP	CYSTARAN OPHTH SOLN	CYSTADANE POWDER
DAYBUE SOLN	deferasirox granules packet	deferasirox tab	dalfampridine ER tab
deferiprone tab	DIACOMIT CAP	DIACOMIT POWDER PACK	deferasirox tab for oral susp
dimethyl fumarate DR starter pack	DOPTELET TAB	DUPIXENT INJ	dimethyl fumarate DR cap
DUROLANE INJ	DYSPORT INJ	ELAPRASE INJ	DUPIXENT PEN INJ
ENBREL INJ 25MG	ENBREL INJ 50MG	ENBREL MINI INJ	EMPAVELI INJ
			ENBREL SURECLICK INJ 50MG

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

ENDARI POWDER PACK	ENSPRYNG INJ	EPIDIOLEX SOLN	ERIVEDGE CAP
ERLEADA TAB	ERLEADA TAB 240MG	erlotinib tab	erlotinib tab 25mg
ETOPOSIDE CAP	everolimus tab	everolimus tab for oral susp	EVRYSDI SOLN
EXTAVIA INJ	FABRAZYME INJ	FASENRA PEN INJ	FEIBA INJ
FERRIPROX SOLN	FILSPARI TAB	fingolimod hcl cap 0.5mg	FINTEPLA SOLN
FIRDAPSE TAB	FIRMAGON INJ	FLEBOGAMMA/GAMMAPL	FOTIVDA CAP
		EX/OCTAGAM/PRIVIGEN	
		INJ	
FULPHILA INJ	FUROSCIX KIT	FUZEON INJ	GALAFOLD CAP
GAMASTAN S/D INJ	GAMUNEX INJ	GANCICLOVIR INJ	ganirelix ac inj
GAVRETO CAP	gefitinib tab	GENOTROPIN INJ	GILOTRIF TAB
GLASSIA INJ	glatiramer inj	HADLIMA INJ	HADLIMA INJ 40MG/0.8ML
HADLIMA PUSH INJ	HADLIMA PUSH INJ	HAEGARDA INJ	HELIXATE/KOGENATE INJ
	40MG/0.8ML		
HEMLIBRA INJ	HERCEPTIN INJ	HIZENTRA INJ	HUMATE-P/WILATE INJ
HUMIRA INJ 10MG	HUMIRA INJ 20MG	HUMIRA INJ 40MG	HUMIRA INJ 80MG
HUMIRA INJ	HUMIRA INJ PEDIATRIC	HUMIRA INJ PEDIATRIC UC	HUMIRA INJ
CROHNS/UC/HIDRADENITI	CROHNS STARTER PACK	STARTER PACK	PSORIASIS/UVEITIS
STARTER PACK			STARTER PACK
HUMIRA PEN INJ 40MG	HYCAMTIN CAP	HYFTOR GEL	HYQVIA INJ
icatibant inj	ICLUSIG TAB	IDHIFA TAB	imatinib tab
IMBRUVICA CAP 140MG	IMBRUVICA CAP 70MG	IMBRUVICA SUSP	IMBRUVICA TAB 420MG,
			560MG
IMCIVREE INJ	INCRELEX INJ	INGREZZA CAP	INGREZZA PACK 40-80MG
INLYTA TAB	INQOVI TAB	INTRON-A INJ	ISTURISA TAB 10MG
ISTURISA TAB 1MG	ISTURISA TAB 5MG	JAKAFI TAB	JAYPIRCA TAB
JOENJA TAB	JYNARQUE PAK	JYNARQUE TAB	KALYDECO PAK
KALYDECO TAB	KESIMPTA INJ	KEVZARA INJ	KINERET INJ
KISQALI PAK	KISQALI TAB	KOSELUGO CAP	KOSELUGO CAP 10MG
KRAZATI TAB	lapatinib ditosylate tab	LEDIPASVIR/SOFOSBUVIR	lenalidomide cap
		TAB	
LENVIMA CAP	LIVMARLI SOLN	LIVTENCITY TAB	LONSURF TAB
LORBRENA TAB 25MG	LUCENTIS INJ	LUMAKRAS TAB	LUMAKRAS TAB 320MG
LUMIZYME/MYOZYME INJ	LUPKYNIS CAP	LUPRON DEPOT PED INJ	LUPRON DEPOT-PED INJ
LYNPARZA TAB	LYSODREN TAB	LYTGOBI THERAPY PACK	MACUGEN INJ
MAVENCLAD THERAPY	MAVYRET PAK	MAVYRET TAB	MAYZENT TAB
PAK			
MAYZENT TAB STARTER	MEKINIST SOLN	MEKINIST TAB 0.5MG	MEKINIST TAB 2MG
PACK			
MEKTOVI TAB	MESNEX TAB	mifepristone tab	miglustat cap
MONOCLATE-P INJ	MOZOBIL INJ	MYLERAN TAB	NAGLAZYME INJ
NATPARA INJ	NERLYNX TAB	nilutamide tab	NINLARO CAP
NIVESTYM INJ	NOVOSEVEN INJ	NPLATE INJ	NUBEQA TAB
NUCALA INJ	NYVEPRIA INJ	OCALIVA TAB	octreotide inj
OCTREOTIDE INJ 100MCG	ODOMZO CAP	OFEV CAP	OLUMIANT TAB
OMNITROPE INJ	OPSUMIT TAB	ORENCIA CLICK INJ	ORENCIA SC INJ 125MG/MI
ORENCIA SC INJ	ORENCIA SC INJ	ORGOVYX TAB	ORKAMBI GRANULES
50MG/0.4ML	87.5MG/0.7ML		PACKET
ORKAMBI TAB	ORSERDU TAB	ORSERDU TAB 345MG	OTEZLA STARTER PACK
OTEZLA TAB	OVIDREL INJ	OXBRYTA TAB	OXBRYTA TAB FOR ORAL
			SUSP

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

OXERVATE OPHTH SOLN	PALFORZIA POWDER PACK	PALFORZIA SPRINKLE CAF	PALYNZIQ INJ
pazopanib tab	PEGASYS INJ	PEG-INTRON INJ	PEMAZYRE TAB
PHEBURANE ORAL PELLETS	PIQRAY TAB	pirfenidone cap	pirfenidone tab 267mg
pirfenidone tab 801mg	PLEGRIDY INJ	PLEGRIDY PEN INJ	plerixafor subcutaneous inj
POMALYST CAP	PREVYMIS TAB	PROLIA INJ	PROMACTA POWDER
PROMACTA TAB	PULMOZYME INH SOLN	pyrimethamine tab	PYRUKYND TAB
PYRUKYND TAPER PACK	QINLOCK TAB	RADICAVA ORS STARTER KIT	RADICAVA ORS SUSP
REBETOL SOLN	REBIF INJ	RECOMBINATE INJ	RELYVRIO PAK
RENFLEXIS INJ	RETACRIT INJ	RETEVMO CAP	REVLIMID CAP
REZLIDHIA CAP	REZUROCK TAB	RIASTAP INJ	RIBAVIRIN CAP
RIBAVIRIN TAB	RINVOQ ER TAB	RITUXAN INJ	ROZLYTREK CAP
ROZLYTREK PAK	RUBRACA TAB	RUCONEST INJ	RYDAPT CAP
sapropterin dihydrochloride powder packet	sapropterin dihydrochloride soluble tab	SIGNIFOR INJ	SIMPONI AUTO-INJECTOR 100MG
SIMPONI INJ 100MG	SKYCLARYS CAP	SKYRIZI INJ 150MG/ML	SKYRIZI INJ 180 MG/1.2ML
SKYRIZI INJ 360MG/2.4ML	SKYRIZI INJ 75MG/0.83ML	SKYTROFA INJ	SODIUM OXYBATE SOLN
SOFOSBUVIR/VELPATASVI R TAB	SOMAVERT INJ	sorafenib tosylate tab	SPRYCEL TAB
STELARA INJ	STIVARGA TAB	STRENSIQ INJ	sunitinib malate cap
SUPPRELIN LA INJ	SYMDEKO TAB	TABRECTA TAB	tadalafil tab (PAH)
TADLIQ SUSP	TAFINLAR CAP	TAFINLAR TAB	TAGRISSO TAB
TAKHZYRO INJ	TAKHZYRO INJ 150MG/ML	TALTZ INJ	TALZENNA CAP 0.25MG
TALZENNA CAP 0.5MG, 0.75MG, 1MG	TASIGNA CAP	TAVALISSE TAB	TAVNEOS CAP
TAZVERIK TAB	TEGSEDI INJ	temozolomide cap	temsirolimus inj
TEPMETKO TAB	teriflunomide tab	TERIPARATIDE INJ 620MCG/2.48ML	tetrabenazine tab
TEZSPIRE INJ	THALOMID CAP	TIBSOVO TAB	tiopronin tab
TOBI PODHALER	tobramycin neb soln	TORISEL INJ	TRACLEER TAB 32MG
TREMFYA INJ	treprostinil inj 10mg/ml	treprostinil inj 1mg/ml	treprostinil inj 2.5mg/ml
treprostinil inj 5mg/ml	tretinoin cap	trientine cap	TRIKAFTA TAB
TRIKAFTA THERAPY PACK	TUKYSA TAB	TURALIO CAP	TYMLOS INJ
TYSABRI INJ	TYVASO DPI POWDER	TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	TYVASO DPI POWDER TITRATION KIT 16-32-48MC
TYVASO DPI POWDER TITRATION KIT 16-32MCG	TYVASO INH SOLN 0.6 MG/ML	UPTRAVI TAB	VALCHLOR GEL
VENCLEXTA STARTER PACK	VENCLEXTA TAB	VENTAVIS INH SOLN	VERZENIO TAB
vigabatrin powder pack	vigabatrin tab	vigadrone powder pack	VIJOICE TAB
VIJOICE TAB 250MG	VITRAKVI CAP 100MG	VITRAKVI CAP 25MG	VITRAKVI SOLN
VIVITROL INJ	VIZIMPRO TAB	VONJO CAP	VOSEVI TAB
VOWST CAP	VOXZOGO INJ	VPRIV INJ	VYNDAMAX CAP
VYNDAQEL CAP	WAKIX TAB	WELIREG TAB	XALKORI CAP
XALKORI SPRINKLE CAP	XELJANZ SOLN	XELJANZ TAB	XELJANZ XR TAB
XEMBIFY INJ	XEOMIN INJ	XGEVA INJ	XIAFLEX INJ
XOLAIR INJ	XOLAIR SYRINGE	XOLAIR SYRINGE 150MG/ML	XOSPATA TAB

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

XPOVIO PAK
ZEJULA TAB
ZOKINVY CAP
ZYDELIG TAB

XYNTHA INJ
ZELBORAF TAB
ZOLADEX INJ
ZYKADIA CAP

ZARXIO INJ
ZEPOSIA CAP
ZOLINZA CAP
ZYKADIA TAB

ZEJULA CAP
ZEPOSIA STARTER PACK
ZTALMY SUSP

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Last Updated* 3/1/2024
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
arformoterol tartrate neb soln	Step Therapy requires trial of PERFOROMIST
asenapine maleate SL tab	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
ASTEPRO NASAL SPRAY	Step therapy requires trial of azelastine nasal spray 0.1%
AURYXIA TAB	Step Therapy requires trial of RENVELA and FOSRENOL
azelastine nasal spray 0.15%	Step therapy requires trial of azelastine nasal spray 0.1%
BYETTA INJ	Step Therapy requires trial of VICTOZA or BYDUREON; Diagnosis Restricted – Type 2 Diabetes (E11)
CAVERJECT INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
ciclopirox shampoo	Step Therapy requires trial of ketoconazole shampoo
CIPRO HC OTIC SUSP	Step Therapy requires trial of CIPRODEX
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DICLOFENAC PATCH, FLECTOR PATCH	QL= 30 patches/fill; Step Therapy requires trial of celecoxib
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYC SOLN, or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYC SOLN, or FIRVANQ SOLN
EDEX INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
erythromycin DR cap	Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg
ERYTHROMYCIN EC CAP	Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg
erythromycin ethylsuccinate susp	Step Therapy requires trial of azithromycin or clarithromycin
erythromycin tab	Step Therapy requires trial of azithromycin, clarithromycin or doxycycline hyclate 100mg
FANAPT TAB	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
FANAPT TITRATION PACK	QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER
febuxostat tab	Step Therapy requires trial of allopurinol
fluvoxamine ER cap	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 READER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
LEVALBUTEROL INHALER, XOPENEX HF INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA
MECLOFENAMATE CAP	Step Therapy requires trial of two: diclofenac potassium tab, ketoprofen cap, ibuprofen, or naproxen
METHITEST TAB	Step Therapy requires trial of ANDROGEL or ANDRODERM
metronidazole gel 1%	Step Therapy requires trial of metronidazole gel 0.75%
minocycline tab	Step therapy requires trial of minocycline caps
MOVIPREP SOLN	Step Therapy requires trial of CLENPIQ
MUSE SUPP	QL= 6 supp/30 days; Step therapy requires trial of sildenafil
nevirapine ER tab	Step Therapy requires trial of nevirapine
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%
paliperidone ER tab	Step Therapy requires trial of ABILIFY or quetiapine ER
risedronate DR tab	Step Therapy requires trial of alendronate
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL)
TEKTURNAL HCT TAB	Step Therapy requires trial of valsartan/hctz
travoprost ophth soln	QL= 5ml/30 days; Step Therapy requires trial of latanoprost
zolmitriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
ZOLMITRIPTAN SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
ZOMIG SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**SISC - Book of Business Drug List
Smoking Cessation Agents
Last Updated* 3/1/2024**

Drug Name	Tier # for Drug Copay
bupropion SR tab(Limited to 180 days/plan year)	\$0
nicotine gum(Limited to 180 days/plan year)	\$0
NICOTINE KIT	\$0
nicotine lozenge(Limited to 180 days/plan year)	\$0
nicotine patch(Limited to 180 days/plan year)	\$0
NICOTROL INHALER(Limited to 180 days/plan year)	\$0
NICOTROL NASAL SPRAY(Limited to 180 days/plan year)	\$0
VARENICLINE TAB(Limited to 180 days/plan year)	\$0
varenicline tartrate tab(Limited to 180 days/plan year)	\$0
varenicline tartrate tab starter pack(Limited to 180 days/plan year)	\$0

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Infertility Drug List
Last Updated* 3/1/2024

Drug Name	Tier # for Drug Copay
cetorelix acetate for inj kit	B
CETROTIDE KIT	B
CLOMID TAB	B
CLOMIPHENE TAB	B
ganirelix ac inj	B
OVIDREL INJ	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
abiraterone tab 250mg	QL= 4 tabs/day
ABSTRAL SL TAB	QL= 120 tabs/30 days
ACTEMRA ACTPEN INJ	QL= 2 inj/28 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ACTHAR GEL INJ	QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
ADALIMUMAB-ADAZ INJ	QL= 2 inj/28 days
ADALIMUMAB-ADAZ PFS INJ	QL= 2 inj/28 days
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	QL= 2 inj/28 days
ADBRY INJ	QL= 4 inj/28 days
ADEMPAS TAB	QL= 3 tabs/day; Only available through Accredo 800-803-2523
AFLURIA INJ	QL= 1 inj/28 days
AFLURIA INJ, FLUZONE INJ	QL= 1 inj/28 days
AIMOVIJ INJ	QL= 1 pack/28 days
AJOVY INJ	QL= 1 pack/28 days
AKYNZEO CAP	QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
albuterol HFA inhaler	QL= 2 inhalers/30 days
ALECENSA CAP	QL= 8 caps/day
ALINIA SUSP	QL= 60ml/3 days
ALKINDI SPRINKLE CAP 0.5MG	QL= 3 caps/day; Members age 9 or older require Prior Authorization
ALKINDI SPRINKLE CAP 1MG	QL= 3 caps/day; Members age 9 or older require Prior Authorization
ALUNBRIG TAB 30MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306
ALUNBRIG TAB 90MG, 180MG	QL= 1 tab/day; Only available through Biologics 800-850-4306
ambrisentan tab	QL= 1 tab/day; Only available through Lumicera 855-847-3553
ANDRODERM PATCH	QL= 1 patch/day
ANZEMET TAB	QL= 9 tabs/fill
aprepitant cap	QL= 3 caps/fill
aprepitant pak	QL= 3 caps/fill
ARIKAYCE SUSP	QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046
armodafanil tab	QL= 1 tab/day
asenapine maleate SL tab	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
AUSTEDO TAB	QL= 4 tabs/day
AUSTEDO XR TAB	QL= 2 tabs/day
AUSTEDO XR TAB 6MG	QL= 3 tabs/day
AUSTEDO XR TAB TITRATION KIT	QL= 1 pack/28 days
AYVAKIT TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
BACTROBAN NASAL OINT	QL= 10 tubes/fill
BALVERSA TAB 3MG	QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767
BALVERSA TAB 4MG	QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
BALVERSA TAB 5MG	QL= 1 tab/day; Only available through CVS Specialty 800-237-2767
BAQSIMI NASAL POWDER	QL= 2 inhalations/fill
BAXDELA TAB	QL= 2 tabs/day; Restricted to Infectious Disease Specialist
BENLYSTA AUTO-INJECTOR	QL= 4 inj/28 day
BENLYSTA INJ	QL= 4 inj/28 day
bosentan tab	QL= 2 tabs/day; Only available through Lumicera 855-847-3553
BRAFTOVI CAP 75MG	QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118
BRUKINSA CAP	QL= 4 caps/day; Only available through Lumicera 855-847-3553
budesonide ER tab	QL=1 tab/day
buprenorphine patch	QL= 4 patches/28 days
bupropion SR tab	Limited to 180 days/plan year
butalbital/acetaminophen tab 50-325mg	QL= 60 tabs/30 days
butalbital/acetaminophen/caffeine tab	QL= 60 tabs/30 days
butalbital/aspirin/caffeine cap	QL= 60 tabs/30 days
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days
BYDUREON BCISE AUTO INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
BYDUREON INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
BYDUREON PEN INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
BYLVAY CAP 1200MCG	QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY CAP 400MCG	QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 200MCG	QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 600MCG	QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479
CABLIVI INJ KIT	QL= 1 vial/day; Only available through Biologics 800-850-4306
CABOMETYX TAB	QL= 1 tab/day
CALQUENCE CAP	QL= 2 caps/day; Only available through Biologics 800-850-4306
CALQUENCE TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
CAMZYOS CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
carisoprodol tab	QL= 90 tabs/90 days
CAVERJECT INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
CIBINQO TAB	QL= 1 tab/day
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA STARTER INJ KIT	QL= 1 kit/plan year
CINRYZE INJ	QL= 16 vials/28 days; Only available through Accredo 800-803-2523
clindamycin vaginal cream	QL=1 tube/fill
CLINDESSE VAGINAL CREAM	QL= 1 applicator/fill
COMIRNATY INJ	QL= 1 dose/17 days
COMIRNATY INJ 30MCG/0.3ML	QL= 1 dose/17 days
COPIKTRA CAP	QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
COTELLIC TAB	QL= 3 tabs/day
COVID-19 VACCINE BIVALENT BOOSTER INJ (MODERNA)	QL= 1 inj/fill

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
COVID-19 VACCINE BIVALENT BOOSTER INJ (PFIZER)	QL= 1 inj/fill
COVID-19 VACCINE BIVALENT BOOSTER INJ 5-11Y (PFIZER)	QL= 1 inj/fill
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-4Y (PFIZER)	QL= 1 inj/fill
COVID-19 VACCINE BIVALENT BOOSTER INJ 6M-5Y (MODERNA)	QL= 1 inj/fill
COVID-19 VACCINE INJ (JANSSEN)	QL= 1 dose/45 days
COVID-19 VACCINE INJ (NOVAVAX)	QL= 1 dose/17 days
COVID-19 VACCINE INJ 5-11Y (PFIZER)	QL= 1 dose/17 days
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	QL= 1 dose/24 days
COVID-19 VACCINE INJ 6M-4Y (PFIZER)	QL= 1 dose/17 days
CYSTADROPS SOLN	QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007
CYSTARAN OPHTH SOLN	QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416
dalfampridine ER tab	QL= 2 tabs/day; Restricted to Neurology Specialist
DAYBUE SOLN	QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DIASTAT ACDL GEL	QL= 2 packs/fill
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	QL= 2 packs/fill
DIAZEPAM GEL	QL= 2 packs/fill
diazepam rectal gel	QL= 2 packs/fill
diclofenac gel	QL= 300gm/30 days
diclofenac gel 1%	QL= 5 tubes/fill
DICLOFENAC PATCH, FLECTOR PATCH	QL= 30 patches/fill; Step Therapy requires trial of celecoxib
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
dihydroergotamine mesylate nasal spray	QL= 8 sprays/fill, 2 fills/30 days
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day
DOPTELET TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
DUPIXENT INJ	QL= 2 inj/28 days
DUPIXENT PEN INJ	QL= 2 inj/28 days
econazole cream	QL= 30gm/30 days
EDEX INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
EMGALITY INJ	QL= 1 inj/28 days
EMGALITY INJ 100MG/ML	QL= 3 inj/fill, 6 fills/year
EMPAVELI INJ	QL= 160ml/28 days; Only available through PantheRx 855-726-8479
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL MINI INJ	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
ENDARI POWDER PACK	QL= 6 packets/day
ENSPRYNG INJ	QL= 1 inj/28 days
entecavir tab	QL= 1 tab/day
ENTRESTO TAB	QL= 2 tabs/day
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill
ERLEADA TAB	QL= 4 tabs/day
ERLEADA TAB 240MG	QL= 1 tab/day
erlotinib tab	QL= 1 tab/day
erlotinib tab 25mg	QL= 3 tabs/day
estradiol vaginal tab, yuvafem vaginal tab	QL= 8 tabs/28 days, 18 tabs on first fill
estradiol valerate inj	QL= 5ml/fill
eszopiclone tab	QL= 1 tab/day
everolimus tab	QL= 1 tab/day
everolimus tab for oral susp	QL= 1 tab/day
EVRYSDI SOLN	QL= 6.67ml/day; Only available through Accredo 800-803-2523
FANAPT TAB	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
FANAPT TITRATION PACK	QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER
FARXIGA TAB	QL= 1 tab/day
FASENRA PEN INJ	QL= 1 inj/56 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
FEMALE CONDOMS	QL= 12 condoms/fill
fentanyl citrate lollipop	QL= 120 lozenges/30 days
FENTORA TAB, FENTANYL BUCCAL TAB	QL= 120 tabs/30 days
FILSPARI TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
FINTEPLA SOLN	QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007
FLUAD INJ	QL= 1 inj/28 days
FLUAD QUAD INJ	QL= 1 inj/28 days

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
FLUBLOK QUAD PF INJ	QL= 1 inj/28 days
FLUCELVAX QUAD INJ	QL= 1 inj/28 days
FLULAVAL QUAD INJ, FLUZONE QUAD IN	QL= 1 inj/28 days
FLUMIST QUADRIVALENT NASAL SUSP	QL= 1 inj/28 days
FLUZONE HD PF INJ	QL= 1 inj/28 days
FLUZONE HIGH DOSE PF INJ	QL= 1 inj/28 days
FLUZONE/FLUARIX QUAD INJ	QL= 1 inj/28 days
FOTIVDA CAP	QL= 21 caps/28 days; Only available through Biologics 800-850-4306
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 READER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FUROSCIX KIT	QL= 8 inj/fill; Only available through BioMatrix Specialty Pharmacy 855-359-9679
gabapentin cap 100mg	QL= 9 caps/day
gabapentin cap 300mg	QL= 6 caps/day
gabapentin cap 400mg	QL= 4 caps/day
gabapentin soln	QL= 72 mls/day
gabapentin tab 600mg	QL= 6 tabs/day
gabapentin tab 800mg	QL= 4.5 tabs/day
GALAFOLD CAP	QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
GAVILYTE-C SOLN	Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
GAVRETO CAP	QL= 4 caps/day; Only available through Lumicera 855-847-3553
gefitinib tab	QL= 1 tab/day; Only available through Lumicera 855-847-3553
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
GLUCAGEN HYPOKIT INJ	QL= 2 inj/fill
GLUCAGON EMR INJ	QL= 2 inj/fill
GLUCAGON INJ KIT	QL= 2 inj/fill
GLUCAGON KIT	QL= 2 inj/fill
GLYXAMBI TAB	QL= 1 tab/day
GOLYTELY SOLN	Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
granisetron tab	QL= 9 tabs/fill
GRANISOL SOLN	QL= 60ml/fill

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
GUAIFENESIN/CODEINE SYRUP	QL= 240ml/fill
GVOKE INJ	QL= 2 inj/fill
GVOKE INJ KIT	QL= 2 inj/fill
GVOKE PFS INJ	QL= 2 inj/fill
HADLIMA INJ	QL= 2 inj/28 days
HADLIMA INJ 40MG/0.8ML	QL= 2 inj/28 days
HADLIMA PUSH INJ	QL= 2 inj/28 days
HADLIMA PUSH INJ 40MG/0.8ML	QL= 2 inj/28 days
HUMIRA INJ 10MG	QL= 2 syringes/28 days
HUMIRA INJ 20MG	QL= 2 syringes/28 days
HUMIRA INJ 40MG	QL= 2 syringes/28 days
HUMIRA INJ 80MG	QL= 2 syringes/28 days
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PEDIATRIC UC STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG	QL= 2 pens/28 days
HYD POL/CPM SUSP	QL= 120ml/fill; 2 fills/30 days
HYDROCODONE BITARTRATE ER CAP	QL= 2 caps/day
hydrocodone bitartrate er tab	QL= 1 tab/day
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
hydrocodone/chlorpheniramine/pseudoephedrine liquid	QL= 120ml/fill, 2 fills/month
HYFTOR GEL	QL= 10 grams/30 days; Only available through Walgreens 888-347-3416
ibandronate tab 150mg	QL= 1 tab/30 days
ICLUSIG TAB	QL= 1 tab/day; Only available through AcariaHealth 800-511-5144
IDHIFA TAB	QL= 1 tab/day
IMBRUVICA CAP 140MG	QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA CAP 70MG	QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA SUSP	QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA TAB 420MG, 560MG	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
IMCIVREE INJ	QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479
IMITREX INJ	QL= 4 inj/fill, 2 fills/30 days
INBRIJA INH POWDER	QL= 10 caps/day
INGREZZA CAP	QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479
INGREZZA PACK 40-80MG	QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479
INLYTA TAB	QL= 8 tabs/day
INQOVI TAB	QL= 5 tabs/28 days
ISTURISA TAB 10MG	QL= 6 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ISTURISA TAB 1MG	QL= 8 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007
ISTURISA TAB 5MG	QL= 2 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007
JAKAFI TAB	QL= 2 tabs/day
JANUMET TAB	QL= 2 tabs/day
JANUMET XR TAB	QL= 2 tabs/day
JANUVIA TAB	QL= 1 tab/day
JARDIANCE TAB	QL= 1 tab/day
JAYPIRCA TAB	QL= 2 tabs/day
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
JOENJA TAB	QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479
JYNARQUE PAK	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
JYNARQUE TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KALYDECO PAK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
KALYDECO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KERENDIA TAB	QL= 1 tab/day
ketorolac inj 15mg/ml	QL= 20ml/5 days
ketorolac inj 30mg/ml	QL= 20ml/5 days
ketorolac inj 60mg/2ml	QL= 20ml/5 days
ketorolac tab	QL= 20 tabs/5 days
KEVZARA INJ	QL= 2 inj/28 days
KINERET INJ	QL= 1 inj/day; Only available through Biologics 800-850-4306
KISQALI PAK	QL= 91 tabs/28 days
KISQALI TAB	QL= 63 tabs/28 days
KOSELUGO CAP	QL= 4 caps/day; Only available through Onco360 877-662-6633
KOSELUGO CAP 10MG	QL= 8 caps/day; Only available through Onco360 877-662-6633
KRAZATI TAB	QL= 6 tabs/day; Only available through Biologics 800-850-4306
LAGEVRIO CAP (EUA)	QL= 40 caps/fill
LAGEVRIO CAP 200MG	QL= 40 caps/fill
latanoprost ophth soln	QL= 2.5ml/30 days
LAZANDA NASAL SPRAY	QL= 15 bottles/30 days
LEDIPASVIR/SOFOSBUVIR TAB	QL= 1 tab/day
lenalidomide cap	QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416
LENVIMA CAP	QL= 3 caps/day; Only available through Optum 877-445-6874
LEVALBUTEROL INHALER, XOPENEX HF INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA
lidocaine oint	QL= 36gm/fill
lidocaine patch 5%	QL= 3 patches/day
LINZESS CAP	QL= 1 cap/day
lisdexamfetamine dimesylate cap	QL= 1 cap/day
lisdexamfetamine dimesylate chew tab	QL= 1 tab/day; Members age 9 or older require Prior Authorization
LIVMARLI SOLN	QL= 90ml/30 days; Only available through Eversana 866-849-4481

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
LIVTENCITY TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
LORBRENA TAB 25MG	QL= 3 tabs/day
lubiprostone cap	QL= 2 caps/day
LUCEMYRA TAB	QL= 96 tabs/7 days
LUMAKRAS TAB	QL= 8 tabs/day; Only available through Biologics 800-850-4306
LUMAKRAS TAB 320MG	QL= 3 tabs/day; Only available through Biologics 800-850-4306
LUPKYNIS CAP	QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479
LYNPARZA TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
LYTGOBI THERAPY PACK	QL= 5 tabs/day; Only available through Onco360 877-662-6633
malathion lotion	QL= 2 bottles/fill
MALE CONDOMS	QL= 12 condoms/fill
MAVYRET PAK	QL= 5 packs/day
MAVYRET TAB	QL= 3 tabs/day
medroxyprogesterone inj	QL= 1 inj/90 days
MEKINIST TAB 0.5MG	QL= 3 tabs/day
MEKINIST TAB 2MG	QL= 1 tab/day
MEKTOVI TAB	QL= 6 tabs/day
methylergonovine tab	QL= 28 tabs/fill, 1 fill/365 days
mifepristone tab	QL= 4 tabs/day; Only available through Korlym SPARK program 855-4Korlym (855-456-7596)
modafinil tab	QL= 2 tabs/day
MOTEGRITY TAB	QL= 1 tab/day
MOUNJARO INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
MUSE SUPP	QL= 6 supp/30 days; Step therapy requires trial of sildenafil
MYFEMBREE TAB	QL= 1 tab/day
NALOXONE PREFILLED INJ	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NATACYN OPHTH SUSP	QL= 15ml/fill
NATROBA SUSP	QL= 1 bottle/fill
NAYZILAM SPRAY	QL= 2 packs/fill; Restricted to Neurology Specialist
NERLYNX TAB	QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
NEXLETOL TAB	QL= 1 tab/day
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	
nicotine lozenge	Limited to 180 days/plan year
nicotine patch	Limited to 180 days/plan year
NICOTROL INHALER	Limited to 180 days/plan year
NICOTROL NASAL SPRAY	Limited to 180 days/plan year
nitazoxanide tab	QL= 6 tabs/3 days
NUBEQA TAB	QL= 4 tabs/day
NUCALA INJ	QL= 1 inj/28 days
NUCYNTA ER TAB	QL= 2 tabs/day

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
NUDEXTA CAP	QL= 2 caps/day
NULYTELY SOLN	Covered at \$0 for members 45-75 years, all other members covered at generic copay Limited to 2 fills/calendar year
OCALIVA TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
OFEV CAP	QL= 2 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%
OLUMIANT TAB	QL= 1 tab/day
OMNIPOD 5 G7 KIT INTRO	QL= 1 kit/year
OMNIPOD 5 G7 MIS PODS	QL= 10 pods/30 days
OMNIPOD 5 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 PACK PODS	QL= 10 pods/month
OMNIPOD DASH INTRO KIT	QL= 1 kit/year
OMNIPOD DASH PODS	QL= 10 pods/month
OMNIPOD GO KIT	QL= 10 pods/month
OMNIPOD STARTER KIT	QL= 1 kit/year
ONGENTYS CAP	QL= 1 tab/day, 30 tabs per fill
OPSUMIT TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
OPZELURA CREAM	QL= 4 tubes/30 days for the first two months; then QL= 12 tubes/year thereafter
ORENCIA CLICK INJ	QL= 4 inj/28 days
ORENCIA SC INJ 125MG/ML	QL= 4 inj/28 days
ORENCIA SC INJ 50MG/0.4ML	QL= 4 inj/28 days
ORENCIA SC INJ 87.5MG/0.7ML	QL= 4 inj/28 days
ORGOVYX TAB	QL= 30 tabs/28 days; Only available through Biologics 800-850-4306
ORIAHNN CAP	QL= 2 caps/day
ORILISSA TAB 150MG	QL= 1 tab/day
ORILISSA TAB 200MG	QL= 2 tabs/day
ORKAMBI GRANULES PACKET	QL= 2 packets/day; Only available through Walgreens 888-347-3416
ORKAMBI TAB	QL= 4 tabs/day; Only available through Walgreens 888-347-3416
ORSERDU TAB	QL= 3 tabs/day; Only available through Onco360 877-662-6633
ORSERDU TAB 345MG	QL= 1 tab/day; Only available through Onco360 877-662-6633
oseltamivir cap	QL= 10 caps/fill, 1 fill/calendar year
oseltamivir cap 30mg	QL= 20 caps/fill, 1 fill/calendar year
oseltamivir susp	QL= 250ml/fill, 1 fill per calendar year
OTEZLA STARTER PACK	QL= 1 pack/28 days
OTEZLA TAB	QL= 2 tabs/day
OXBRYTA TAB	QL= 3 tabs/day; Only available through Accredo 800-803-2523
OXBRYTA TAB FOR ORAL SUSP	QL= 5 tabs/day; Only available through Accredo 800-803-2523
OXERVATE OPHTH SOLN	QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523
OXYCODONE ER TAB	QL= 2 tabs/day
OZEMPIC INJ	QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
PALYNZIQ INJ	QL= 1 inj/day; Only available through Accredo 800-803-2523

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
PAXLOVID TAB 150-100MG	QL= 20 tabs/fill
PAXLOVID TAB 300-100MG	QL= 30 tabs/fill
pazopanib tab	QL= 4 tabs/day
peg 3350 soln (100 gram Moviprep equiv)	QL= 2 fills/year; \$0 for members 45-75 years, all other members covered at generic copay
peg 3350/electrolytes soln	Covered at \$0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
PEMAZYRE TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
PHEXXI GEL	QL= 1 box/fill
PICATO GEL	QL= 1 box/fill
pirfenidone cap	QL= 9 caps/day
pirfenidone tab 267mg	QL= 9 tabs/day
pirfenidone tab 801mg	QL= 3 tabs/day
POMALYST CAP	QL= 21 caps/28 days
posaconazole DR tab	QL= 93 tabs/30 days
posaconazole susp	QL= 525ml/26 days
POTIGA TAB	QL= 3 tabs/day
pregabalin cap	QL= 3 caps/day
pregabalin cap 225mg	QL= 2 caps/day
pregabalin cap 300mg	QL= 2 caps/day
pregabalin soln	QL= 30ml/day
PRETOMANID TAB	QL= 1 tab/day; Restricted to Infectious Disease Specialist
PREVYMIS TAB	QL= 1 tab/day; Limit 200 tabs/365 days
PROLIA INJ	QL= 1 fill/6 months
pyrimethamine tab	QL= 3 tabs/day; Only available through Walgreens 888-347-3416
PYRUKYND TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
PYRUKYND TAPER PACK	QL= 1 tab/day; Only available through Biologics 800-850-4306
QINLOCK TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306
RADICAVA ORS STARTER KIT	QL= 70ml/365 days; Only available through Accredo 800-803-2523
RADICAVA ORS SUSP	QL= 50mL/28 days; Only available through Accredo 800-803-2523
ramelteon tab	QL= 1 tab/day
REGANEX GEL	QL= 30gm/fill
RELENZA DISKHALER	QL= 1 inhaler/calendar year
RELYVRIO PAK	QL= 2 packets/day; Only available through Accredo 800-803-2523
REPATHA INJ	QL= 2 inj/28 days
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
RETEVMO CAP	QL= 4 caps/day
REVLIMID CAP	QL= 1 cap/day; Only available through Walgreens 888-347-3416; Restricted to Oncology or Hematology Specialist
REYVOW TAB	QL= 8 tabs/30 days, 6 fills/year
REZLIDHIA CAP	QL= 2 caps/day; Only available through Biologics 800-850-4306
REZUROCK TAB	QL= 1 tab/day; Only available through Lumicera 855-847-3553
RINVOQ ER TAB	QL= 1 tab/day

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
ROZLYTREK CAP	QL= 3 caps/day
ROZLYTREK PAK	QL= 6 packs/day
RUBRACA TAB	QL= 4 tabs/day; Only available through Optum 877-445-6874
RYBELSUS TAB	QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11)
RYDAPT CAP	QL= 56 caps/28 days
SANCUSO PATCH	QL= 4 patches/fill
SANTYL OINT	QL= 90gm/30 days
SAVELLA TAB	QL= 2 tabs/day
SIGNIFOR INJ	QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007
sildenafil tab	QL=6 tabs/30 days
SIMPONI AUTO-INJECTOR 100MG	QL=1 inj/28 days
SIMPONI INJ 100MG	QL=1 inj/28 days
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKYCLARYS CAP	QL= 3 caps/day; Only available through Biologics 800-850-4306
SKYRIZI INJ 150MG/ML	QL= 1 inj/84 days
SKYRIZI INJ 180 MG/1.2ML	QL= 1 inj/56 days
SKYRIZI INJ 360MG/2.4ML	QL= 1 inj/56 days
SKYRIZI INJ 75MG/0.83ML	QL= 2 inj/84 days
SODIUM OXYBATE SOLN	QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-368
sodium/magnesium/potassium soln	QL= 2 fills/calendar year; \$0 for members 45-75 years, all other members covered at generic copay
SOFOSBUVIR/VELPATASVIR TAB	QL= 1 tab/day
SOLIQUA INJ	QL= 15ml/25 days
SOLU-CORTEF INJ	QL= 1 vial/fill
SOLU-CORTEF INJ 100MG	QL= 2 vials/fill
SPIKEVAX INJ	QL= 1 dose/24 days
SPIKEVAX INJ 50MCG/0.5ML	QL= 1 dose/24 days
SPINOSAD SUSP	QL= 1 bottle/fill
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL)
STELARA INJ	QL= 1 inj/84 days
STIVARGA TAB	QL= 4 tabs/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
SUFLAVE SOLN	QL= 2 fills/calendar year
SUMATRIPTAN INJ	QL= 4 inj/fill, 2 fills/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 4 inj/fill, 2 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SUNOSI TAB	QL= 1 tab/day

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
SYMDEKO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
SYNJARDY TAB	QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG	QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG	QL= 2 tabs/day
TABRECTA TAB	QL= 4 tabs/day
tadalafil tab 2.5mg, 5mg	QL= 1 tab/day
TAGRISSE TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
TAKHZYRO INJ	QL= 2 inj/28 days; Only available through Accredo 800-803-2523
TAKHZYRO INJ 150MG/ML	QL= 2 inj/28 days; Only available through Accredo 800-803-2523
TALTZ INJ	QL= 1 inj/28 days
TALZENNA CAP 0.25MG	QL= 3 caps/day
TALZENNA CAP 0.5MG, 0.75MG, 1MG	QL= 1 cap/day
TAVALISSE TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
TAVNEOS CAP	QL= 6 caps/day; Only available through PantheRx 855-726-8479
TAZVERIK TAB	QL= 8 tabs/day; Only available through Onco360 877-662-6633
TEGSEDI INJ	QL= 4 inj/28 days; Only available through Accredo 800-803-2523
TEPMETKO TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
TESTOSTERONE ENANTHATE INJ 200MG/ML	QL= 5ml/fill
testosterone gel pump 1.62%	QL= 2 bottles/30 days
testosterone soln	QL= 2 bottles/30 days
TEZSPIRE INJ	QL= 1 pen/28 days
TIBSOVO TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
TRACLEER TAB 32MG	QL= 4 tabs/day; Only available through Accredo 800-803-2523
TRADJENTA TAB	QL= 1 tab/day
travoprost ophth soln	QL= 5ml/30 days; Step Therapy requires trial of latanoprost
TREMFYA INJ	QL= 1 inj/56 days
tretinoin cream	QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization
tretinoin gel	QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG	QL= 1 tab/day
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG	QL= 2 tabs/day
TRIKAFTA TAB	QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416
TRIKAFTA THERAPY PACK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
TRINTELLIX TAB	QL= 1 tab/day
TRULANCE TAB	QL= 1 tab/day
TRULICITY INJ	QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
TUKYSA TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
TURALIO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306
TYVASO DPI POWDER	QL= 4 cartridges/day; Only available through Accredo 800-803-2523

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER TITRATION KIT 16-32MCG	QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO INH SOLN 0.6 MG/ML	QL= 1 ampule/day; Only available through Accredo 800-803-2523
UBRELVY TAB	QL= 10 tabs/30 days, 6 fills/year
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Optum Pharmacy 877-445-6874
VALTOCO NASAL SPRAY	QL= 2 packs/fill; Restricted to Neurology Specialist
vancomycin cap	QL= 56 caps/fill
VARENICLINE TAB	Limited to 180 days/plan year
varenicline tartrate tab	Limited to 180 days/plan year
varenicline tartrate tab starter pack	Limited to 180 days/plan year
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VASCEPA CAP	QL= 4 caps/day
VENTAVIS INH SOLN	QL= 9 ampules/day; Only available through Accredo 800-803-2523
VENTOLIN HFA INHALER	QL= 2 inhalers/30 days
VEOZAH TAB	QL= 1 tab/day
VERQUVO TAB	QL= 1 tab/day; Restricted to Cardiology Specialist
VERZENIO TAB	QL= 2 tabs/day
V-GO INJ KIT	QL= 1 kit/day
VICTOZA INJ	QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11)
VIJOICE TAB	QL= 1 tab/day
VIJOICE TAB 250MG	QL= 2 tabs/day
VITRAKVI CAP 100MG	QL= 2 caps/day; Only available through Accredo 800-803-2523
VITRAKVI CAP 25MG	QL= 6 caps/day; Only available through Accredo 800-803-2523
VITRAKVI SOLN	QL= 10ml/day; Only available through Accredo 800-803-2523
VIZIMPRO TAB	QL= 1 tab/day
VONJO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306
VOSEVI TAB	QL= 1 tab/day
VOWST CAP	QL= 12 caps/fill; Only available through Orsini 800-410-8575
VOXZOGO INJ	QL= 1 vial/day; Only available through Accredo 888-773-7376
VYNDAMAX CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
VYNDAQEL CAP	QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
WAKIX TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
WELIREG TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306
XACIATO GEL	QL= 1 applicator/fill
XADAGO TAB	QL= 1 tab/day
XALKORI CAP	QL= 2 caps/day

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
XALKORI SPRINKLE CAP	QL= 4 caps/day
XCOPRI PAK 100-150MG	QL= 2 tabs/day
XCOPRI PAK 150-200MG	QL= 2 tabs/day
XCOPRI PAK 50-200MG	QL= 2 tabs/day
XCOPRI TAB 150MG, 200MG	QL= 2 tabs/day
XCOPRI TAB 50MG, 100MG	QL= 1 tab/day
XCOPRI TITRATION PAK 12.5-25MG	QL= 1 tab/day
XCOPRI TITRATION PAK 150-200MG	QL= 1 tab/day
XCOPRI TITRATION PAK 50-100MG	QL= 1 tab/day
XELJANZ SOLN	QL= 10ml/day
XELJANZ TAB	QL= 2 tabs/day
XELJANZ XR TAB	QL= 1 tab/day
XENLETA TAB	QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist
XIFAXAN TAB 200MG	QL= 9 tabs/3 days
XIFAXAN TAB 550MG	QL= 2 tabs/day
XIGDUO XR TAB	QL= 2 tabs/day
XIGDUO XR TAB 10-1000MG	QL= 1 tab/day
XIGDUO XR TAB 2.5-1000MG, 5-1000MG	QL= 2 tabs/day
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG	QL= 1 tab/day
XOLAIR SYRINGE	QL= 2 inj/28 days
XOLAIR SYRINGE 150MG/ML	QL= 2 inj/28 days
XOSPATA TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306
XPHOZAH TAB	QL= 2 tabs/day
XPOVIO PAK	QL= 32 tabs/28 days; Only available through Biologics 800-850-4306
XTAMPZA ER CAP	QL= 120 caps/30 days
XULTOPHY INJ	QL= 15ml/30 days
zaleplon cap	QL= 1 cap/day
ZAVZPRET NASAL SPRAY	QL= 6 units/fill; 60 units/365 days
ZEGALOGUE INJ	QL= 2 inj/fill
ZEJULA CAP	QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
ZEJULA TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
ZELBORAF TAB	QL= 8 tabs/day
ZEPOSIA CAP	QL= 1 cap/day
ZEPOSIA STARTER PACK	QL= 1 cap/day
ZOKINVY CAP	QL= 4 caps/day; Only available through CVS Specialty 800-237-2767
zolmitriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
ZOLMITRIPTAN SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
zolpidem tab	QL= 1 tab/day
ZOMIG SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
ZORYVE CREAM	QL= 60 grams/30 days

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List Cont.
Last Updated* 3/1/2024
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ZTALMY SUSP	QL= 1100ml/30 days; Only available through Orsini 800-410-8575
ZYKADIA CAP	QL= 3 caps/day
ZYKADIA TAB	QL= 3 tabs/day
ZYLET OPHTH SUSP	QL= 5ml/fill (10ml bottle is Not Covered)

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.